

The **COMPLETE GUIDE** to
OVERCOMING
Depression,
Low Mood
and other related problems

INCLUDES

OVERCOMING ANGER & IRRITABILITY
WILLIAM DAVIES

OVERCOMING DEPRESSION
PAUL GILBERT

OVERCOMING INSOMNIA
COLIN A. ESPIE

OVERCOMING LOW SELF-ESTEEM
MELANIE FENNELL

OVERCOMING MOOD SWINGS
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The Complete Guide to Overcoming Depression, Low Mood and Other Related Problems

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and Colin Espie



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OVERCOMING ANGER AND IRRITABILITY

*A self-help guide using
Cognitive Behavioral Techniques*

WILLIAM DAVIES

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Good Luck!

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Acknowledgements

Reading through previous Acknowledgements contained in books in this series I see that the form is to thank all the wonderful people that have written about and researched Cognitive Therapy. Quite right too, I hope that is taken as read. More immediately, however, I would like to thank Amy and Helen for the work they put in to typing this book at very short notice, under great pressure, and with very little irritation! (One or two assertive comments perhaps, but probably well justified!) Also to Paul Gilbert for pushing forward what he terms my 'approachable writing style' and, just as much, to the publishers for creating a series that is so relevant and important that it makes one enthusiastic to write for it. Finally, although I can't imagine they will ever read this, an acknowledgement to 'Danny and Vicky' who feature in one of the many case studies and who may well be recognised for the well-known characters they are. A special word of thanks to them for the endless entertainment they provide, and of reassurance that their inclusion is not yet another dig at them, but is simply intended to create an entirely non-malicious smile in the reader.

Introduction

Why a cognitive behavioral approach?

Over the past two or three decades, there has been something of a revolution in the field of psychological treatment. Freud and his followers had a major impact on the way in which psychological therapy was conceptualized, and psychoanalysis and psychodynamic psychotherapy dominated the field for the first half of this century. So, long-term treatments were offered which were designed to uncover the childhood roots of personal problems – offered, that is, to those who could afford it. There was some attempt by a few health service practitioners with a public conscience to modify this form of treatment (by, for example, offering short-term treatment or group therapy), but the demand for help was so great that this had little impact. Also, whilst numerous case histories can be found of people who are convinced that psychotherapy did help them, practitioners of this form of therapy showed remarkably little interest in demonstrating that what they were offering their patients was, in fact, helpful.

As a reaction to the exclusivity of psychodynamic therapies and the slender evidence for its usefulness, in the 1950s and 1960s a set of techniques was developed, broadly collectively termed ‘behavior therapy’. These techniques shared two basic features. First, they aimed to remove symptoms (such as anxiety) by dealing with those symptoms themselves, rather than their deep-seated underlying historical causes. Second, they were techniques, loosely related to what laboratory psychologists were finding out about the mechanisms of learning, which were formulated in testable terms. Indeed, practitioners of behavior therapy were committed to using techniques of proven value or, at worst, of a form which could potentially be put to the test. The area where these techniques proved of most value was in the treatment of anxiety disorders, especially specific phobias (such as fear of animals or heights) and agoraphobia, both notoriously difficult to treat using conventional psychotherapies.

After an initial flush of enthusiasm, discontent with behavior therapy grew. There were a number of reasons for this, an important one of which was the fact that behavior therapy did not deal with the internal thoughts which were so obviously central to the distress that patients were experiencing. In this context, the fact that behavior therapy proved so inadequate when it came to the treatment of depression

highlighted the need for major revision. In the late 1960s and early 1970s a treatment was developed specifically for depression called 'cognitive therapy'. The pioneer in this enterprise was an American psychiatrist, Professor Aaron T. Beck, who developed a theory of depression which emphasized the importance of people's depressed styles of thinking. He also specified a new form of therapy. It would not be an exaggeration to say that Beck's work has changed the nature of psychotherapy, not just for depression but for a range of psychological problems.

In recent years the cognitive techniques introduced by Beck have been merged with the techniques developed earlier by the behavior therapists to produce a body of theory and practice which has come to be known as 'cognitive behavior therapy'. There are two main reasons why this form of treatment has come to be so important within the field of psychotherapy. First, cognitive therapy for depression, as originally described by Beck and developed by his successors, has been subjected to the strictest scientific testing; and it has been found to be a highly successful treatment for a significant proportion of cases of depression. Not only has it proved to be as effective as the best alternative treatments (except in the most severe cases, where medication is required), but some studies suggest that people treated successfully with cognitive behavior therapy are less likely to experience a later recurrence of their depression than people treated successfully with other forms of therapy (such as antidepressant medication). Second, it has become clear that specific patterns of thinking are associated with a range of psychological problems and that treatments which deal with these styles of thinking are highly effective. So, specific cognitive behavioral treatments have been developed for anxiety disorders, like panic disorder, generalized anxiety disorder, specific phobias and social phobia, obsessive compulsive disorders, and hypochondriasis (health anxiety), as well as for other conditions such as compulsive gambling, alcohol and drug addiction, and eating disorders like bulimia nervosa and binge-eating disorder. Indeed, cognitive behavioral techniques have a wide application beyond the narrow categories of psychological disorders: they have been applied effectively, for example, to helping people with low self-esteem and those with marital difficulties.

At any one time almost 10 per cent of the general population is suffering from depression, and more than 10 per cent has one or other of the anxiety disorders. Many others have a range of psychological problems and personal difficulties. It is of the greatest importance that treatments of proven effectiveness are developed. However, even when the armoury of therapies is, as it were, full, there remains a very great problem – namely that the delivery of treatment is expensive and the resources are not going to be available evermore. Whilst this shortfall could be met by lots of people helping themselves, commonly the natural inclination to make oneself feel better in the present is to do precisely those things which perpetuate or even exacerbate one's problems. For example, the person with agoraphobia will stay at home to prevent the possibility of an anxiety attack; and the person with bulimia nervosa will avoid eating all potentially fattening foods. Whilst such strategies might resolve some immediate crisis, they leave the underlying problem intact and provide no real help in dealing with future difficulties.

So, there is a twin problem here: although effective treatments have been developed, they are not widely available; and when people try to help themselves they often make matters worse. In recent years the community of cognitive behavior therapists have responded to this situation. What they have done is to take the

principles and techniques of specific cognitive behavior therapies for particular problems and represent them in self-help manuals. These manuals specify a systematic program of treatment which the individual sufferer is advised to work through to overcome their difficulties. In this way, the cognitive behavioral therapeutic techniques of proven value are being made available on the widest possible basis.

Self-help manuals are never going to replace therapists. Many people will need individual treatment from a qualified therapist. It is also the case that, despite the widespread success of cognitive behavioral therapy, some people will not respond to it and will need one of the other treatments available. Nevertheless, although research on the use of cognitive behavioral self-help manuals is at an early stage, the work done to date indicates that for a very great many people such a manual will prove sufficient for them to overcome their problems without professional help.

Many people suffer silently and secretly for years. Sometimes appropriate help is not forthcoming despite their efforts to find it. Sometimes they feel too ashamed or guilty to reveal their problems to anyone. For many of these people the cognitive behavioral self-help manuals will provide a lifeline to recovery and a better future.

Professor Peter Cooper
The University of Reading

PART ONE

Understanding What Happens

What are irritability and anger?

We are probably right to put irritability and anger together because they are so often associated with each other. Nevertheless they are somewhat different. Consider the following stories:

I was in the pub one evening with a couple of friends, just sitting near the back door to the pub, talking. It was a November evening and it was quite cold outside. Somebody came through the back door and left it just a little open so that I had to get up and close it. I didn't mind too much. About a quarter of an hour later somebody else came in and did the same thing, didn't quite close the door properly. So I got up again and closed it. A little while later a third person did the same thing. I closed the door, but gave him a good hard stare. Mind you, I don't think he noticed because he was walking to the bar by that time so I was staring at the back of his head. It happened a fourth time a bit later on – the thing is, the self-closing mechanism on the door had broken. Anyway, this time I said to the bloke who'd come in, 'Don't you think you should close the door behind you when you come in?' He just looked at me as though I was some kind of oddball and went and ordered himself a drink. It was when the fifth person came in that I really went to town on him. By this time I had sunk probably four or five pints. He did exactly the same as all the others, left the door just slightly open. The thing that really got me about it was that they don't seem to care, they just seem so intent on getting their own drinks inside them that they don't give a damn about anybody else in the pub. Anyway, something snapped in me. I didn't actually hit the bloke but I jumped up, started shouting and swearing at him, jabbing my finger in his chest and generally calling him all the names under the sun. He was only a small bloke. And the funny thing was he had only done exactly the same thing as the first one. Simply left the door a little open.

Compare that story, told by a 28-year-old man, Steve, with the following one from David, aged 45.

It was a Wednesday evening and four of us went down to town for a meal in an Indian restaurant. That's me, my wife and the two kids. Anyway, we parked the car in a back street, it must have been about eight o'clock in the evening, walked round to the restaurant and had a very good meal. It was the first time we'd been there, we were all on good form, had a good laugh and a joke about everything, even at how thick and new the carpets were, and altogether had a thoroughly good time. Anyway, about half-past nine or ten o'clock, we'd just turned the corner of the street we'd parked the car in when we heard an almighty crash and the sound of breaking glass. Except it hardly sounded like glass, it was a stronger, louder sound than that. We looked down the street, and there was some bloke with his head stuck through the passenger window of our car, and another bloke standing by him. I didn't grasp what was happening for a moment; then I realized that the sound we had heard was the window glass breaking, and these two were in the process of stealing the stereo from my car. Anyway, I felt that mixture of stuff that courses through your body when these things happen, shouted but

not very loud, and set off after these two. One bloke saw me after a couple of seconds and just ran off. That left the guy with his head still through the window, engrossed in prising my hi-fi out of the car. He still had his head through the window when I got there. I just grabbed hold of him and pulled him out – I didn't care if his head caught on the bits of broken glass or not – and manhandled him, not at all gently, on to the floor. By this time my wife was there and telling me to take it easy, and one of the kids had already got his mobile phone out and was dialling for the police. The lad I'd got out of the car was never more than sixteen, but I just had him on the floor and could cheerfully have throttled him. What did they think they were doing, just thinking they could go up to somebody else's property and take it? Anyway, I just sat astride him, threatening him and telling him what a useless piece of machinery he was until the police came. Half a dozen people must have gone past us during all that, but I couldn't care less. When the police arrived they did at least seem to take my side, took all the details and took him off in their car.

Which of those two stories would you say illustrated irritability and which one anger? To my mind, irritability is shown in the first one and anger in the second. But there is another question, perhaps a more important one, posed by these two examples, and that is: which of the two men was justified in his reaction? Or, if you think that both were justified in their reactions, which was *more* justified?

The 'justified?' test

Personally, I would say the man in the second example was more justified: the man who caught somebody trying to steal his stereo. But maybe I say that because I have been in pretty much the same situation, coming back to the car after a nice meal out, only to find the window broken and the stereo gone. And I must say, if I had been able to get hold of the person who had done it, just at that instant I don't know what I would have done to him. So I feel that I can't really blame David.

On the other hand, I have also inadvertently left a door open and probably irritated somebody thereby – especially if I was the fifth person to have done so that evening. So I would say that perhaps the guy who reacted aggressively in that scene was a bit over-aggressive. Maybe in an ideal world Steve could have toned it down a bit and simply asked persons two, three and four to shut the door after them. But there again, he'd got a few drinks inside him, so possibly his inhibitions were weakened a bit by the time person number five came in. And also he said that customer five was a small bloke, so perhaps that had a bearing on events too.

One of the main judgements we make whenever we see someone behaving in an aggressive or hostile way is whether they are *justified* in doing so. If we consider that they are justified, then we probably won't describe that person as irritable; we reserve the term 'irritable' for people who are hostile, angry or aggressive *without good cause*. If we think the person is justified in being angry or aggressive, then we tend to see nothing wrong with that. So, if we see David as justified in his anger, we probably won't blame him for pinning the thief to the ground until the police arrive. We might see that as a proportionate response. If, on the other hand, he had started banging the 16-year-old's head up and down on the pavement while loudly cursing him, we might have seen that as disproportionate and unjustified.

So, if we really want a definition of irritability it will be something along the lines of: *an unjustified negative response to a situation*. Unjustified in whose eyes? In ours, of course. And therein lies a problem, because everybody has a different judgement as to what is justified and what isn't. What is more, sometimes our judgement goes a

little hazy. I can still remember the first time I saw the film *One Flew Over the Cuckoo's Nest*, in which Nurse Ratchet torments a group of mentally ill patients led by Jack Nicholson. Certainly the patients were full of antipathy towards Nurse Ratchet after about an hour of the film, but not half as much as the audience. At this point, after Nurse Ratchet's particularly savage treatment of one of the patients, Jack Nicholson could stand it no longer, grabbed hold of her, had her on the floor and was throttling the life out of her. Half the audience in the cinema was on its feet, shouting encouragement and just hoping he would finish the job before the two male nurses rushing to Ms Ratchet's assistance could get there. He didn't, the authorities got the better of him, and we all trudged unhappily out of the cinema.

Even though Nurse Ratchet's behavior was extreme, perhaps Jack Nicholson's response was somewhat disproportionate. Of course, in a case like this our judgement is clouded by the events being on the silver screen rather than in reality. But this 'temporary clouding of judgement' is exactly the problem; because, unfortunately, it happens not just on the silver screen but in real life as well. On those occasions we get repeatedly remorseful and self-critical. We say we 'over-reacted' or 'don't know what got hold of us'. We feel that our response was out of all proportion to the event; it was not *justified*.

These are themes that will run throughout this book. How do we get ourselves always – or nearly always – to respond to negative events in a way that is *in proportion* to them? In a way that we, and others, would say is *justified*?

It is worth lingering a little on these questions of definition. The word 'irritability' implies a minor kind of response on the part of the irritable person, probably verbal, usually not physically aggressive. Even so, we tend to react against irritable people because we think that their response is not justified. Anger, on the other hand, might lead to a much more forceful response. The man who pinned the thief to the floor was angry. Nevertheless, we don't necessarily react against people who are being angry, so long as we see their anger as justified.

In fact, we sometimes like to see people getting angry, so long as they are on our side. Margaret Thatcher was often referred to as 'handbagging' her counterparts from other European countries in order to stick up for those in Britain perceived as their rights. I, for one, never heard many people complaining about that at the time. Her successor John Major, on the other hand, was painted as a much more grey character (literally in the case of the satirical *Spitting Image* programme): so grey, in fact, that he would be unlikely to get openly angry with too many people. Whether this perception was accurate is another matter but, accurate or not, it seemed to count against him. What is more, this negative perception of John Major was exacerbated by rumours that he could also be rather irritable in private – a shade on the snappish side when perhaps it wasn't warranted. Again, whether this perception was true is another matter, but it does illustrate the point that what people dislike is not the fact of other people getting angry, it's the fact of other people reacting in a way that is not justified, or out of proportion to the situation.

Anger, irritability and frustration

Just to finish off this chapter, see what you make of the following two stories.

The first was related to me by Anne, a woman of 34, telling me about how she was getting on with her 12-year-old daughter.

The biggest rumpus Rachel and I have had this week was Tuesday evening. Of course, it's half-way through the holidays and she always gets on my nerves in the holidays anyway. But Tuesday was particularly bad because I'd been going on at her all day to tidy her room. It was a terrible mess, she could hardly set foot in it without tripping over something – and it smells when you walk in there, I'm sure she's got some food that's going off buried under all her clothes on the floor. Anyway, I'd been going on at her all day to tidy her room and she just wouldn't do it. There was always something she had to do first. So, it was about seven o'clock in the evening, I was downstairs and Rachel was upstairs. I'd just got back from the shops, I'd only been out five or ten minutes. Anyway, the house was quiet so I thought that maybe Rachel had decided that she'd better do what her mum says and get on with tidying her room. So I went upstairs ready to praise her and tell her what a good girl she was and how pleased I was with her and how much better the room looked and so on. When I got up there I could see that Rachel wasn't in her room and the place looked just as much of a tip as it ever had. Anyway, to cut a long story short, there was Rachel, in the bathroom, sitting in the bath washing her hair. Well, I just flew at her. It was absolutely the last straw. She hasn't lifted a finger to help all holidays, she can't even be bothered to tidy her own room, and there she is sitting in the bath like a little madam washing her hair with my shampoo! I just ranted and raved at her for a good ten or fifteen minutes, just shouting and screaming. All the frustrations of the holidays came out in that time. The poor kid looked absolutely petrified, and as for what the neighbours thought, I've no idea.

Justified? Perhaps not.

And what about this one, in which Paul, 46, told me about his son John, also aged 12?

You see, the thing is, all I've ever tried to do is to do my best for him. And I have learnt the hard way that if you don't pay proper attention to education and schooling then you're the worse off for it as you get older. So I'm always going on at him about how important it is to pay attention in school and do his homework properly when he gets home. But he knows better, of course, and he tells me that he can concentrate better doing his homework in front of the television. And I've seen him doing it. He sits there, mouth half open, staring at the screen and just every now and again looking at what he's meant to be doing. And he thinks he's got me fooled doing this. He thinks that I believe he's doing his homework. So anyway, Monday was like that, Tuesday was the same, just the same as any other day, and on Wednesday I told him to show me his books after he'd packed them away and said he'd done all the homework he had to do. And so I was looking at his exercise book, for maths; he was meant to have done twenty sums in it. And he's got all the numbers 1 to 20 down there, and some of them he'd done, though God knows whether they were right or not, but I could see that more than half the sums he was meant to have done he just hadn't. He hadn't even tried to. There were just blank spaces where the answers were meant to be. So I saw red and I just walloped him. He was sitting just opposite from me looking stupid and frightened and I just walloped him. I hit him straight across the face so he all but fell off the chair and I didn't waste my breath on him, I just told him to get straight upstairs to bed. And I've not spoken to him since, and that was three days ago.

Justified? Well, again, maybe not. But it is all too easy to be critical of those two parents, or say that their reactions were out of proportion to what triggered them and therefore were not justified. Sometimes people get to such a pitch that they can no longer tell what's justified and what isn't; and both of those parents described, quite truthfully, genuinely wanting to do the best for their children. Sometimes the level of frustration that builds up is unbearable. This was not the first such incident for either of these parents. Both had tried all sorts of tactics without success. And now they saw themselves still as having no success – but also having been pushed into doing things they didn't like doing.

SUMMARY

- Irritability and anger take lots of different forms. Both are emotions that most people have felt.
- There's nothing wrong with being angry in itself; sometimes it is clearly justified. It is when we overreact, responding in a way that is out of proportion to the situation, that we lay ourselves open to criticism. And sometimes we ourselves are our harshest critics.
- The very term 'irritability' implies that the reaction is unjustified. It normally suggests that a person is being snappy and bad-tempered when there is no call to be so. As such it fails the 'Justified?' test; people are almost always criticized for being irritable. Again, we may be our harshest critics in this respect.
- There are times when, through frustration or for other reasons, we lose our sense of perspective. It's on those occasions that we find ourselves unable to judge what is justified. And then we see ourselves doing things which we feel are justified *at the time* but which later on – once our true sense of judgement returns – we are horrified that we did.

A final thought

Most of us feel rather critical of irritable and unjustifiably angry people, almost as if they were doing it deliberately to make our lives miserable. And, certainly, it is no fun at all living with an irritable and unjustifiably angry person. One point that is sometimes forgotten, however, is that neither is it any fun being the irritable and angry person! Many, many people have their lives virtually ruined by their own irritability and anger. So it is *both* for them *and* for those around them that this book is written.

What makes us angry?

It is important to know just what makes you angry, because when you come to doing something about it this will be a very important starting point. Clearly, if you know what things make you angry, you can either avoid those things (if possible!) or work out how you would prefer to respond when they happen.

So what kind of things are we looking for? It is said that we are all different, but in fact there tend to be certain themes which produce anger in most people. And remember, we said in Chapter 1 that there is nothing wrong with anger in itself, so long as it is in proportion to the event. What makes us feel bad is when we act out of proportion to what is happening: when we are 'snappy' in the face of no reasonable provocation, or angry in response to something that would normally just mildly irritate most people, or completely 'lose our cool' in response to something that most people would just get somewhat angry about.

Irritants, costs and transgressions

So what makes most of us angry? There are three main categories: irritants, costs and transgressions.

Irritants

The number of *irritants* in life is boundless. I was talking recently to Pam, who said she could no longer stand the way her husband ate. Simply the noise his mouth made in chewing his food drove her round the bend. Moreover, as so often happens, now she had noticed this, she was waiting for it every mealtime; and that made it ten times worse. It had become a symbol for all that was wrong with him (self-centred, greedy) and with their marriage (she saw him as a different type of person from herself).

People sniffing, coughing, blowing their noses can also be irritating. This certainly used to be the case for me. I sometimes run training events where I spend three days with perhaps a dozen people. Occasionally one of that dozen will have a chronic, hacking cough which lasts for the duration of these three days and longer, for all I know. Certainly I used to find that very irritating indeed. A cough can be so loud; and sometimes its owner seemed deliberately to cough just as I was coming out with an extremely good point! So then I'd have to repeat it and the effect was spoilt. (I cured myself of this sensitivity when I realized that, very often, the owner of the cough would have been perfectly entitled to stay at home, off sick, for the three days. I was therefore able to re-interpret his coughing presence as a compliment to myself:

evidence that he simply could not bear to miss out on the event. Whether this is actually true or not doesn't really matter to me; I feel it is true – or at least it could be true – and that keeps me satisfied.)

Neighbours are another excellent source of irritation. Apartments and town houses give everybody great scope for irritating each other. When we were first married, my wife and I lived in a house where we could even hear the neighbours turning on and off their electric switches at the wall sockets, as clearly as if they were in the room with us. That in itself hardly counts as an irritant, but there is plenty of potential for serious irritation: loud music, raised voices, banging picture-hooks into walls, do-it-yourself activity, playing ball games in the street (and on *your* garden) and so on and so on. Not infrequently people's lives are made a complete misery by the sheer level of irritation provoked by their neighbours.

Costs

The cost to you of somebody else's behavior may be a literal, financial cost, or it may be a cost in terms of time, or in terms of loss of 'face', or indeed any other loss. The common thread here is that, by virtue of what they do, someone costs you in some way; and that makes you angry. Examples include parents being angry when their children break things (because of the financial cost of replacing them); or your spouse being angry because you have crashed the car (again because of the cost of repairing it, or the increased insurance premiums that result).

Interestingly, these kinds of causes of anger sometimes illustrate a 'hangover' effect. Sue told me how angry she was that her 13-year-old son had broken a mug by dropping it on the kitchen floor accidentally. When I asked her exactly why it was that she had become angry she said, 'Well, it's the cost of replacing these things; he goes around as though money grows on trees, thinks that whatever he breaks will just automatically get replaced.' I found this strange, because Sue was very far from being poor, and was well able to replace a broken mug or two. But she had not always been wealthy; at one time in her life it would have made a significant impact on her finances to have to buy a new mug, and that cast of mind had stayed with her. Old habits die hard. And there is another possible explanation, too; but we will come on to that later.

Judy was telling me how she had taken her 5-year-old daughter to a hospital outpatient clinic. She got there promptly for her 2 p.m. appointment but was not seen until approximately two hours later, 4 p.m. What especially enraged her was that she realized after a while that every single person in the clinic had been given an appointment for 2 p.m., and the clinic was due to run from 2 p.m. to 5 p.m. approximately. Therefore, the hospital authorities had deliberately arranged the session in such a way that some people would be waiting for three hours. The costs to Judy were several, including the loss of time in which she could have been doing some of the many tasks that were pressing on her at home; the necessity to entertain her 5-year-old daughter constantly for two hours to prevent her getting bored and restless; and the loss of face implied by the hospital authority's apparent attitude that it didn't matter if she was kept waiting for one, two or three hours.

Alan, an electrician, was angry because he was asked to do too much at work. His boss asked in a very straightforward way, something like, 'Have you got time to fit in an extra call to a customer who needs their light switches sorting out?' and was quite

prepared to take no for an answer; he could always ask another of the electricians. Nevertheless, Alan was still angry because of the cost to him of the request. What was that cost? The way he saw it, he could choose one of two: either he suffered the cost of time, whereby he did an extra job that he couldn't really fit into his schedule; or he suffered the cost of guilt in turning down a straightforward request from his boss. Clearly Alan needed to learn some deep assertiveness techniques, so that he could feel entitled to say 'no' without feeling guilty about it.

I have met a lot of people who get very angry and irritated when their partners contradict them in public. The cost here is usually loss of face – especially when the contradiction implies that the first speaker was telling a lie, even if only a harmless little lie to exaggerate and make more interesting an otherwise boring story. Nigel, however, was driven wild by the very smallness of the contradiction. He gave me the example of an occasion when he and his wife were chatting with friends and he was recounting a story of something that had happened the previous Wednesday. As soon as he uttered the word 'Wednesday' his wife interrupted to say, 'No it wasn't, it was last Tuesday.' It is difficult to imagine that he could be made so angry by the cost of such an interruption: there is, after all, hardly any loss of face involved in mistaking a Tuesday for a Wednesday. Perhaps it was just a case of a simple irritant (having his flow of thought interrupted) – or possibly it was something different: a transgression.

Transgressions

A transgression involves the breaking of a rule. Possibly Nigel held to the rule that husbands and wives don't contradict each other in public – not at all an unusual rule to have. Therefore, when that rule was broken, repeatedly, he got angry, repeatedly.

Another very common rule that good friends and partners have is that confidences should not be broken. In other words, if your partner knows something about you purely by virtue of being your partner, then he or she should not go around telling other people about it. This might include intimate details about your health, your likes and dislikes, or simply something they know about your experiences or opinions which you would not share with anybody except your nearest and dearest. To break such confidences is almost universally viewed as a taboo, a major transgression – and one of the very quickest ways you can get on the wrong side of your partner.

Obviously, the example in Chapter 1 about the man who got angry with the youngster he caught trying to steal his car stereo is also an example of a transgression. In that case the youngster was not just breaking a rule held by the man in question, he was breaking the law: a very formalized transgression.

These three categories are not mutually exclusive: there are many cases that cross the boundaries. For example, if your partner flirts with someone he or she finds attractive, that is normally viewed as a transgression; in other words, it is against the rules for many people. But it also involves a cost – loss of face, the impression that your partner is somehow dissatisfied with you and seeking consolation elsewhere. (Of course, this may not be true; but it is easily and often seen that way.)

Another cross-boundary example was the case of Sue's son, who accidentally dropped a mug on the floor and broke it. Perhaps it was, as his mother claimed, the cost of replacing the mug that made her angry; but, given that she could afford to do that without even noticing the price, that seems rather unlikely. A more probable

explanation is that she was angry because he had transgressed an unspoken rule, namely that one takes a reasonable amount of care not to inconvenience others in the household. The 'sheer carelessness' was what made her angry.

SUMMARY

- It is important to know the sort of things which make you angry, because you will use this knowledge to benefit yourself later on.
- Typically, there are three categories of event that make people angry: irritants, costs and transgressions.
- There are plenty of irritants: people leaving doors open repeatedly, neighbours making a noise, even the way people eat or cough.
- Likewise, there are plenty of things that people do that have a cost for us: our children breaking things and the consequent financial cost; our partners contradicting us and costing us loss of face; having to do things unexpectedly, which costs us time.
- You, like everyone else, will have a set of rules that you expect other people to abide by. When someone breaks one of those rules, it is known as a transgression. When you spot a transgression, or think you have, the chances are you will be angry.
- Some things which make us angry straddle the boundaries between these categories. For example, a child breaking something may make us angry because of the cost involved in replacing it, but also because they have not, in our view, taken sufficient care.

Why am I not angry all the time?

It does seem that the world is absolutely crammed full with irritants, people doing things that have costs for us, and people breaking the rules we have made up for ourselves; so how come we are not in a permanent state of anger and rage?

Internal and external inhibitions

Remember Judy, who took her youngster to the outpatient clinic at the hospital and was kept waiting for two hours? She described that event to me as one of the times she has been most angry in her life. There were various factors in the build-up. When she first got there, she saw the waiting room was very crowded, but thought perhaps there were quite a few doctors and nurses working, so that it would soon clear. Gradually she realized that, on the contrary, the queue was moving only very slowly; and when she got talking to some of the others there, she found that every one of them had a 2 p.m. appointment. That caused a major step change in her level of anger, from quite calm to ‘pretty angry’. Not ‘absolutely boiling’, however: that came when, at around 3 p.m., the sole doctor and nurse who were in fact working at the clinic that day stopped to have their afternoon tea. And why shouldn’t they? you ask; most of us perhaps take a short break in the afternoon, and they had been working hard. Why not, indeed; but it was the manner of their doing it that provoked Judy. For they sat in the clinic room chatting to each other with the door wide open, so that all the patients could see them having their break – all the mothers (mostly) with their youngsters getting increasingly fretful while doctor and nurse only too visibly maintained their right to have a cup of tea. Not surprisingly, then, by the time Judy took her little girl in to see the doctor she was purple with rage. So did she give the doctor a piece of her mind? No; she didn’t say a word about it.

Now, this is amazing on the face of it, because if you talk to Judy now, ten years after that event, she still begins seething at the recollection of it. She was *so angry*. And yet she simply didn’t mention it when she got to see the doctor. Why could that be?

The short answer is: because of her *inhibitions*. It’s not that Judy is an ‘inhibited’ kind of person, just that there were inhibitions in action that held her back; some kind of self-control mechanism. We can probably guess the kind of thoughts that were going through her mind – things like: ‘If I get on the wrong side of the doctor, will my youngster get the best treatment he is capable of providing?’ Judy, indeed, confirms that this is true, that is exactly the thought that was uppermost in her mind.

But she also confesses to a secondary inhibition, namely: ‘You just don’t go around getting angry with doctors.’ Rightly or wrongly, she held this as a rule for herself, a rule that held good even when she was so badly treated by a doctor.

That second inhibition (‘you don’t get angry with doctors’) is termed an *internal* inhibition: in other words, it is an inhibition which exists entirely internally, in the mind. There is no external threat, like the police coming to arrest her, which would prevent her from being angry with the doctor – purely an internal rule she had for herself.

What about the first inhibition? The one which said maybe her child wouldn’t get the very best treatment if she became angry with the doctor? Yes, that is an *external* inhibition, inasmuch as it was a fear of the consequences that stopped her venting her anger.

Let’s look back now at the example in Chapter 1 where David came round the corner and saw a teenager smashing his car window and starting to take the stereo out. David caught the teenager, and, sitting astride him on the ground, described himself as being completely overwhelmed with anger against this boy who felt he could simply go and take things that didn’t belong to him. So, now he had him on the ground, at his mercy, why didn’t he throttle him or smash his head up and down against the pavement? Again, the answer is ‘inhibitions’: but were they internal or external? Was it the fear of being hauled off to court himself on a much more serious charge than theft, or was it some deeply ingrained rule that said that you don’t go smashing people’s heads up and down on the pavement no matter what they’ve done?

Who knows? Probably a combination of the two. Either way, the episode certainly illustrates the power of such inhibitions because David clearly was, from his description, absolutely beside himself with rage.

Another example of the power of internal inhibitions – simple rules we make up for ourselves – came from a publican I was talking to recently. He described how one of his customers was arguing loudly with another and was going to hit him. The man who was about to be on the receiving end of the punch took a step back, raised his hands in a placatory gesture, and said, ‘Hey, hey, hey . . . I’m over forty.’ This remark, said the publican, just put a pause into the proceedings while the would-be assailant checked his memory banks to see if there really was a rule against hitting people aged over 40. Interestingly, and no doubt much to the relief of the potential recipient of the blow, by the time he had found that there wasn’t really such a rule the moment had passed and he just stomped off.

Inhibitions as brakes on anger

Inhibitions, then, are in fact wonderful things – rather like the brakes on the car, they prevent us from going too far too fast. Later on in this book we are going to see how you can use inhibitions to your own benefit, so it is a good idea right now to get used to the idea that inhibitions are not just very necessary, they are extremely helpful mechanisms built right into the structure of our brains. It is also worth emphasizing that referring to ‘inhibitions’ in this sense is rather different from referring to somebody as ‘inhibited’, as a term of criticism. What we often mean in that context is that the person is constrained from displaying any emotion, not just anger, so that they may appear cold, detached, self-absorbed and unable to ‘let themselves go’. But

in the context of keeping our angry reactions in check, inhibitions – both internal and external – are just what we want.

Let's take one example of somebody who had not developed his inhibitions strongly enough – someone to whom, as a result, I was talking inside a prison. Brian recounted how one night he was standing at the bar, having a drink with a friend. He thinks he had probably had four or five pints of beer by the time the following incident took place. He says he was just lifting his pint mug to his mouth when somebody nearby jogged his elbow, with the result that a good amount of beer went not into his mouth but all over his face and chest. The next thing he knew, Brian had smashed his beer mug against the bar and pushed it into the man's face – thereby, of course, inflicting very severe injury indeed. The net result of those few seconds for Brian was a five-year prison sentence. It was a great pity for both men that the assailant had not worked on developing his inhibitions. Again, those inhibitions could have been external (I'll end up in prison, I'll be thrown out of the bar, the police will be called) or internal (it's not right to go around attacking people).

For most people, of course, the consequences of having undeveloped inhibitions are less dramatic than this: just a life which is impaired year after year by upsetting other people! So, there are immense benefits to be gained from learning about inhibitions and all the other techniques that we will cover later. For now it is sufficient to know about them and to know how important they are.

What holds us back?

Now we have seen how inhibitions operate, perhaps we can work out what holds people back in each of the situations we have looked at.

- Why doesn't the person who hears loud music from next door immediately go round and complain angrily? *Answer:* internal inhibition: 'It's right to be tolerant towards your neighbours'; external inhibition: 'If I do that he will probably come round here complaining as soon as I make a noise, and he will probably go around badmouthing me to all our other neighbours.'
- Why didn't Pam get angrier with her noisy-eating husband? *Answer:* internal inhibition: 'I must try and limit the amount of complaining I do, this is only a small thing'; external inhibition: 'I have probably got some bad habits too, so if I complain about his eating, he will probably start complaining about all the things I do that annoy him.'
- When people coughing during my talks used to annoy me, why did I not get angry with them and tell them to shut up or clear off? *Answer:* internal inhibition: 'I shouldn't speak rudely to people who have come to hear me talk'; external inhibition: 'If I do that then there will be an icy-cold atmosphere for the remainder of the three days while everybody else is frightened to death of accidentally coughing.'
- Why did Nigel not snap back angrily when his wife contradicted him in public? *Answer:* internal inhibition: 'You don't wash your dirty linen in public'; external inhibition: 'People will think worse of me if I do that.'
- Why did Alan, the electrician who was asked to do too many jobs, not say 'no' to his boss straight away? *Answer:* external inhibition: his boss might think worse of him and, come the time for redundancies . . .

SUMMARY

- The ability to inhibit or control our anger is a very important ability to have. It is by no means a good idea to be 'uninhibited' where expressing our anger is concerned.
- This is not to say that you should never be angry; rather, that you will be able to control your anger. As we

saw in Chapter 1, irritable and over-angry people are those whose reaction is *out of proportion* to the situation that provokes the reaction.

- Inhibitions are like the brakes of a car: sometimes they stop the car moving, but often they simply ensure the car moves at an appropriate pace.
- Inhibitions are of two main types: internal and external.
- Internal inhibitions are the thoughts and moral guidelines we have for ourselves.
- External inhibitions are the awareness of the consequences that would happen if you were to respond out of proportion to provocation.

Constructing a system to explain irritability and anger

The ‘leaky bucket’

If we can put all that we have worked out so far into a diagram, it will help us predict when we are going to be irritable or angry and, more to the point, prevent it happening. So let’s have a look at Figure 4.1, which summarizes what we have said so far about Judy’s case.

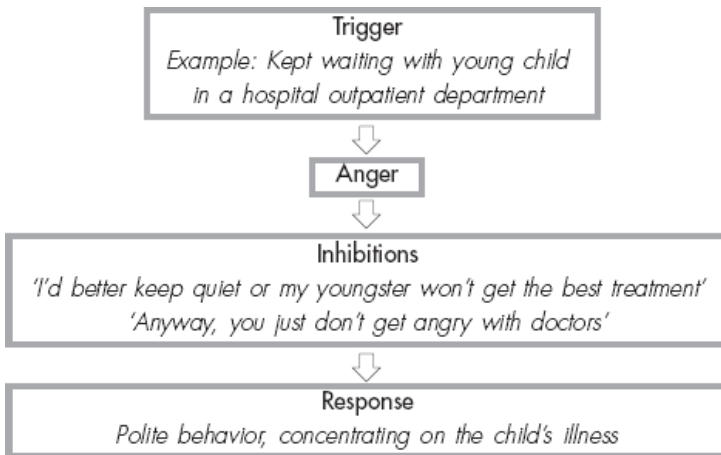


Figure 4.1 Kept waiting in hospital

This is actually a particularly interesting example, because many people ask: ‘What happens to the anger?’ In other words, a lot of people assume that unless you ‘get rid of’ your anger, then it somehow just builds up inside you. This is in fact the reverse of the truth. What actually happens is that the anger just gradually dissipates. The best analogy is a leaky bucket full of water. The bucket was absolutely full in this case; Judy was very angry indeed. Nevertheless, over time, all that anger just gradually seeped away, just as water seeps out of a leaky bucket, and now in the ordinary course of things she doesn’t give it a thought. (Nevertheless, if you remind her of the event, it is like pouring some more water into the bucket!)

The key concept is *doing what you think is appropriate in the situation*. In this

case the mother judged that her behavior was indeed appropriate as her child might well have not received the best treatment if she had kicked up a fuss. So, even in retrospect, she still judges that she did right. By the same token, we get angry with ourselves when, in retrospect, we think we did not behave correctly. Again, the important concept is behaving in proportion to the situation, doing what you think is right in the particular situation. (Later on, we will look at why our judgement sometimes goes haywire so that on occasion we let ourselves down very badly.)

Figure 4.2 shows the same model applied to a different situation. The key difference is that here the inhibitions weren't strong enough to control the level of anger experienced by Sue. The anger therefore simply overcame her inhibitions and produced a response of 'ranting and raving'.

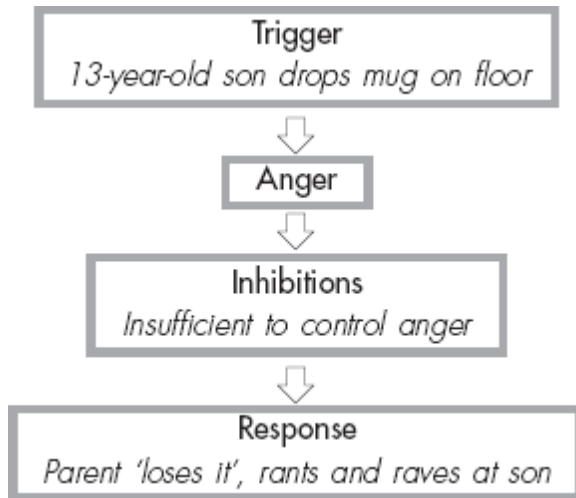


Figure 4.2 Mug breaks on floor

Actually, this does Sue a slight disservice. Certainly this is the way she described the incident – that she simply 'lost it', in other words, simply lost all control. But if that were really true, why did she not pick up the carving knife (they were in the kitchen after all) and stab her son fifty times? Clearly her inhibitions were functioning to a degree, but only at a relatively weak level; or maybe they were functioning reasonably well, but the breakage produced such an immense level of anger that they were still almost overwhelmed.

When the bucket overflows

Let's pursue this line of thought a little further by considering the case of Steve and the door left open in the pub. This fits into our model as shown in Figure 4.3.

On the face of it, this is an accurate representation of what happened. However, if you recollect the exact situation as recounted at the beginning of Chapter 1, you will see that I have omitted the fact that this was the *fifth time* the door had been left slightly ajar. On each of the previous four occasions, some extra anger had been tipped into the bucket. So, by the time person number five comes along and adds his

ladleful to the bucket, the whole thing is brimful and ready to overflow – and he gives five the whole bucket full of anger. You may also recollect that Steve said when he was telling the story that the ‘victim’ was quite a small man. What if he had been six feet three and built to match? Possibly that would have strengthened Steve’s inhibitions! Most people feel inhibited about picking a fight with someone twice their size.

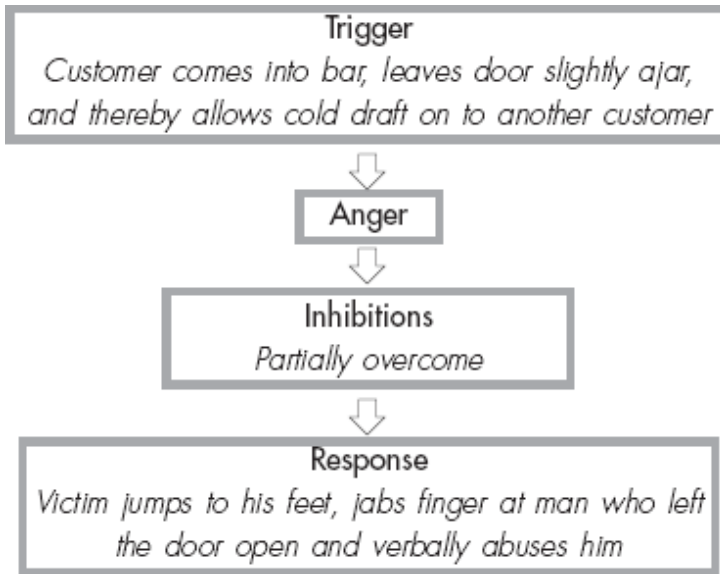


Figure 4.3 Door left open in bar

This concept of anger building up to the point where it overflows is an important one. Adrian, a senior salesman, told me the how he was repeatedly away from home on business, jetting around the world to various exotic destinations for weeks on end. While he was away his very attractive young wife Jenny took to having one affair after another. Gradually Adrian became suspicious and, after he had confronted her several times, Jenny admitted what had been going on. Though obviously hurt, Adrian thought he could cope and put it to his wife that so long as she told him everything he would be prepared to make a fresh start. So, through the course of the evening, Jenny confessed to the four affairs she had had. She went slowly and tactfully, and Adrian was able gradually to come to terms with what had happened. They went to bed, resolved that they could put it all behind them and make a fresh start.

But Jenny had remembered a fifth affair, and when they woke up the following morning, in the spirit of making a clean breast of everything, she confessed it. For Adrian, this was enough to make the bucket overflow, and they divorced.

What makes you angry?

By now you should be able to start making a tentative analysis of what makes *you*

irritable and angry.

- You may well be able to identify several triggers; for most people there is more than one thing that makes them angry.
- You may even be able to quantify the amount of anger that each trigger typically produces, perhaps using a ten-point scale where 10 out of 10 is the angriest you could ever be!
- Maybe you can identify what inhibitions come into play: both your internal inhibitions (the personal morality and rules you have for your own behavior) and the external inhibitions (consequences that may befall you if you over-react).
- You may also be able to reflect upon the various responses you have made in the past when these triggers have set off your anger.

There is no need to do all that at this stage unless you want to; later on we will look at how to analyze these elements carefully, and what to do once you've analyzed them. It can be very rewarding work. But for now it may be useful to consider the kinds of questions we will be asking.

SUMMARY

- We can construct a realistic model which explains how anger and our subsequent reactions to it come about.
- It is well worth doing this because we can then analyze both our own actions and reactions, and those of others. Armed with this awareness, we can then intervene to lessen the anger we experience – and, moreover, to alter the responses we produce. It is those responses that people normally refer to as our 'irritability' or 'anger'.
- We will be developing this model as we go on through this book. The key headings so far are: the *trigger* (what triggers our anger); the *anger* itself (which can gradually build up, like increasing amounts of water being poured into a bucket); *inhibitions* (which stop us constantly giving vent to our anger); and the *response* (which can range from nothing at all, when we completely control our anger, through to catastrophic responses when we totally fail to control it.)
- Importantly, there is *no need* to 'let our anger out'. Very often, 'letting our anger out' simply makes it worse. Better to let it slowly seep away, like water running out from a leaky bucket.

Why don't other people feel angry at the things that bug me?

If we can really plot things out just as neatly and tidily as described in the previous chapter, then you would think that what triggers one person's anger would trigger the same response in another person. And, to a large extent, this is true. Most people, for example, don't like other people shouting and swearing at them. It makes them angry; it is a trigger for their anger. Most people don't like other folk stealing from them; that too is a trigger for their anger. Most people don't like sitting in interminable traffic jams. That too makes most people angry, to a greater or lesser degree.

But it is also true that people respond quite differently to some triggers. For instance, one person may get angry at the sight of teenagers playing football outside his house, whereas another may view it as part of community life.

Seeing things differently

And that is the point. It is all to do with *how we view* the event in question. If we take a hostile view of it, then it will indeed become a trigger for our anger. If we view it tolerantly and benignly, it won't.

This is not to say that we should view everything in a tolerant and benign way. As we shall see later, anger can be very useful and productive. Nevertheless, for the time being, let us just look at how things normally work.

- How come one person kept waiting in a hospital outpatient clinic became really angry whereas another person didn't? *Answer:* because the first person viewed it as inconsiderate and arrogant to schedule everybody in for a two o'clock appointment in a clinic which lasts three hours, and believes that people should show proper consideration for each other. The second person says, 'It's just one of those things,' and expects no better from people.
- Why does one man get intensely irritated by teenagers playing football outside his house, while his next-door neighbour doesn't? *Answer:* because the first person sees it not only as lacking in consideration because of the amount of noise it creates, but also as a symbol of living in a more downmarket area than he would wish to. The second person sees it as part and parcel of living in a friendly, lively community.
- Why did one of the group of three men sitting by the bar door get up and confront the person who left it ajar, whereas the other two weren't bothered? *Answer:* because that man believed that each person who left the door open was doing it as a deliberate provocation and felt that he was losing face in front of the other drinkers. The other two felt there was no offence meant – just that people coming into a bar are normally more concerned about getting a drink than

closing the door.

- Why does one woman get angry about her husband eating in a very noisy way, while the same thing doesn't bother thousands of others at all? *Answer:* because she sees it as a symbol of the difference between their backgrounds, a constant suggestion that they really should not be married at all; for her, it epitomizes the difference between them. For others, how much noise a person makes when they eat has no significance.
- Why did I at one stage get particularly uptight about people coughing during my talks, whereas later on it didn't bother me? *Answer:* because initially I thought that they might not be paying me enough attention, or even be deliberately provoking me, whereas later I felt they were doing well to come to the course when they could be off sick.
- Why does one parent get angry when their son drops a mug on the floor and it breaks, whereas another simply says, 'Never mind', and gets him to sweep it up? *Answer:* because the first person sees it as wilful carelessness and a disregard of how much it costs to replace things, whereas the second realizes that they can easily afford to buy another mug without noticing it.
- Why does one man get angry when his partner contradicts him in public whereas another one doesn't? Because the first man views the contradiction as saying to everybody present that his wife doesn't respect him, whereas the second man views it as 'just the way she is'.
- Why does one mother get angry when she finds her daughter taking a leisurely bath whereas another doesn't? *Answer:* because the first mother said to herself that her daughter was only having a bath to avoid tidying her room, whereas the second mother was pleased to see her daughter taking good care of herself.
- Why does one father get angry with his son when he sees he has not completed his homework, whereas another father doesn't? *Answer:* Because the first father says that his son is a lazy good-for-nothing so-and-so who is trying to pull the wool over his eyes, whereas the second father says that any normal 12-year-old is bound to be more interested in watching television than doing his homework.

And so on. In other words, it is not so much the trigger *in itself* that produces the anger; it is what goes through the person's mind when prompted by the trigger.

Appraisal and judgement

Returning to our model as set out in Chapter 4, we can now extend it to apply to three of the cases we have looked at, as shown in Figures 5.1–5.3.

This one extra box we have put into our model, headed 'Appraisal/Judgement', is a very important one indeed. It means that no longer are we at the mercy of events, or 'triggers'. Now we can see that it is we ourselves who can decide what to make of these events, how to appraise or judge them. It is our appraisal or judgement which will determine whether we will get angry and to what degree. What is more, we can actually *check out our appraisal* with that of others. For example, the man in the bar could have said to his two friends: 'Do you think these people are deliberately leaving the door open to annoy us . . . do you think everyone is laughing at us behind our backs?' Whereupon, in all probability, he would have been reassured that this was not so, that the door was just not working properly, and this might have prevented him from getting angry.

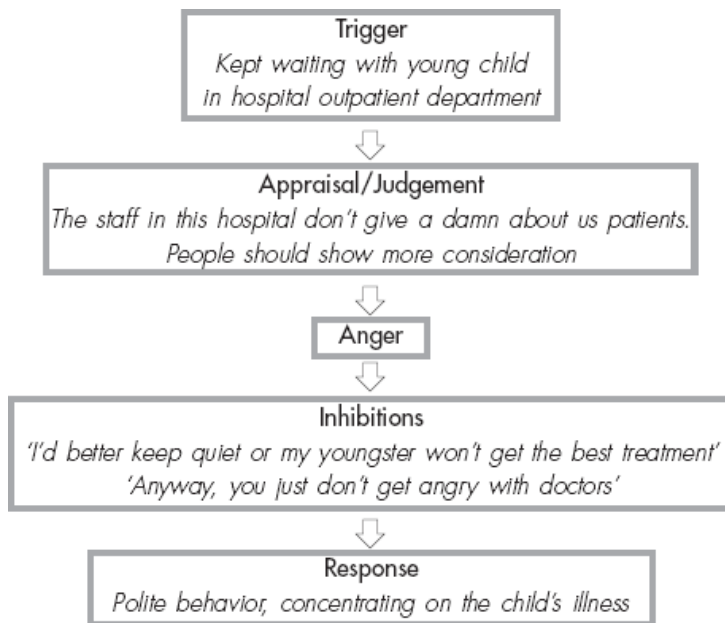


Figure 5.1 Kept waiting in hospital

There is an important point here. Many people think that because they believe something is true, it necessarily *is* true: for instance, in this case, 'Because I believe he left the door open to annoy me, it is true that he did indeed leave the door open to annoy me.' This is very far from being the case; but it is an easy trap to fall into until we get used to questioning our judgements and checking them out with other people.

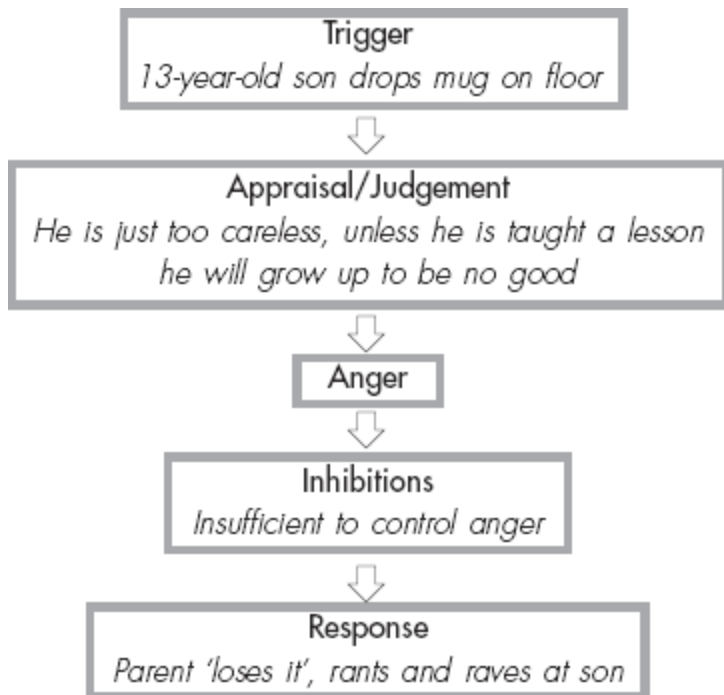


Figure 5.2 Mug breaks on floor

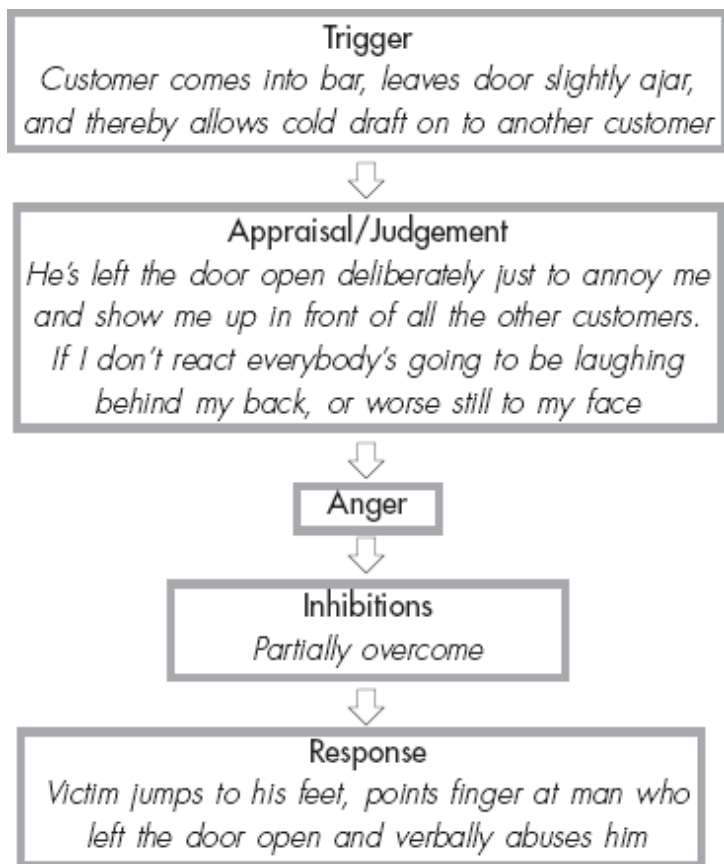


Figure 5.3 Door left open in bar

SUMMARY

- This chapter has added just one more box to our model, but it is an important box.
- That important box, 'Appraisal/Judgement', goes between 'Trigger' and 'Anger', and may totally *prevent* the trigger producing anger.
- Later, we will look at ways of examining and altering our appraisals/judgements. For the time being, it is enough to know that simply because we *think* something is true, that does not actually *make* it true.
- We are now working towards a comprehensive model with which to examine events that make us angry out of proportion to what one would reasonably expect.

Why isn't everybody irritated by the same things?

This sounds like pretty much the same question we asked in Chapter 5, and in a sense it is. But bear with me, because there is a significant difference. You will remember that, in Chapter 5, we asked the question: 'Why do some triggers make me angry but not other people, and vice versa?' and the answer was: because you might appraise and judge the situation one way, and other people might appraise and judge it another way. The question we are really addressing in this chapter, to put it in its fullest form, is: 'Why do I appraise and judge a situation in one way, whereas somebody else might appraise and judge it in quite a different way?'

Beliefs and judgement

So, how come you appraise and judge a situation one way while some other people appraise and judge it in another way? The answer is: 'Because of the basic beliefs we have all developed over the years.' These beliefs can be of several different kinds, for example:

- beliefs about how other people are, what the world is like, even about how we compare with other people;
- beliefs about how people are meant to behave, how people 'learn lessons', what's important in life, and so on;
- beliefs about how other people would see a particular situation, including possibly how a jury in a court of law would see it.

How do these beliefs fit in with the model we developed in the previous chapter? Clearly, our beliefs are going to influence:

- our judgement and appraisal of the trigger;
- our anger;
- our inhibitions;
- our feelings of anger;
- our response.

So now our model has another element in it, as shown in Figure 6.1.

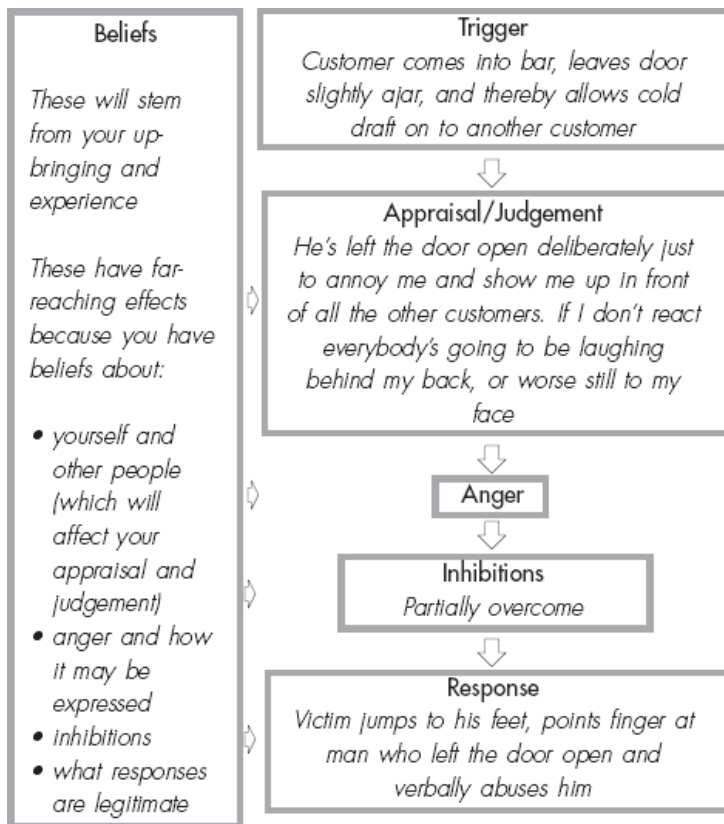


Figure 6.1 A model for analyzing irritability and anger

It's probably easiest to see how this works if we go through an example or two.

What about the man in the bar, sitting with two friends, who finally jumps up and confronts the fifth person who comes in and leaves the door open? How come it was he who jumped up, rather than one of his two friends?

Working through our model, we can see that the trigger was just the same for all three of them: so that can't be the difference.

What about the appraisal or judgement each of them makes? This will be affected by their beliefs about what other people are like. If one of them believes that people, generally, are 'all selfish bastards who don't give a damn about anyone except themselves' he will probably interpret the situation differently from someone who believes that people 'are all basically good, though sometimes their goodness needs bringing out'. So maybe that was the key difference between Steve (the one who jumped up and confronted the newcomer) and Ben and Chris (who didn't).

Now we can move on to our next box, marked 'Anger'. We can see that, primed by his beliefs about people in general, Steve's brain is already more likely to be angry than either Ben's or Chris's; and it will be 'recommending' to Steve that he makes a response in keeping with how he feels. At this stage, too, beliefs come into play. If Steve believes that 'people only learn anything if you give them a good

bollocking' then the chances are that his brain will be recommending something different from those of Ben and Chris, who believe for the most part that 'the only way people learn anything is when they are allowed to sit down and think things through'.

From here we move on to 'Inhibitions'. By now we can see that Steve, who thinks that people are 'all selfish bastards who don't give a damn about anyone except themselves' and that 'people only learn anything if you give them a good bollocking', is already thinking in terms of a pretty hostile response. But possibly his inhibitions will tone it down. If he believes that 'you don't show your anger in public', that might keep him under control. Equally, if he believes that 'if you confront somebody they are liable to attack you' then that too will restrain him, so long as the person leaving the door open is bigger than he is. On the other hand, if he believes that 'if somebody deliberately provokes you then you've got to show them who's boss,' this is unlikely to do much to keep his anger in check.

Finally, then, we come to his response. We can see that beliefs are going to play a part here. If he believes that 'It's all right thumping somebody but you don't ever use a weapon,' his response is clearly going to be of a different order than if he believes that 'If you're going to pick a fight with somebody you have to be tooled up.'

So we can see in this example that the beliefs Steve holds are going to affect him at every stage. And these beliefs are *nothing to do with the situation in question*; they are beliefs he holds day in, day out. So if Steve wanted to radically alter the way he is, the way he feels and the way he reacts, he could work on his beliefs, perhaps bring them a bit closer to those of Ben and Chris. We'll see how later on.

What about Anne and her 12-year-old in the bath? Anne, you'll remember, got really angry with her daughter because she wasn't tidying her room. Anne's next-door neighbour, Elaine, also has fairly young children and she has always reacted differently to them in the face of stress. So let's have a look at how our model would compare Anne and Elaine.

Again, the trigger or situation would have to be just the same: how would Elaine react if her 12-year-old had been resolutely not tidying her room, and how would this compare with Anne's reaction?

Let's have a look at the judgement or appraisal that each would make in the face of this event. Anne's judgement is influenced by the fact that she believes that her daughter 'deliberately does everything she can to annoy me'. Elaine, on the other hand, believes that 'Children don't annoy you deliberately, but they are naturally selfish and only lose that as they get older'. Anne, therefore, is inclined to see her 12-year-old's behavior as deliberate defiance, designed to provoke her; Elaine, on the other hand, views her daughter's similar behavior as a piece of thoughtlessness typical of a child of that age. As a result, Anne is inclined to be angry, Elaine much less so.

As a result of this belief, Anne's angry brain is already recommending some kind of angry response. Unfortunately, Anne also believes that 'You get nowhere by coddling kids,' with the corresponding implication that 'a firm hand', either metaphorically or literally, is what is required. Elaine thinks differently. Even when she does get angry (which, you will be pleased to hear, she does sometimes) her basic belief is that 'Children need a good example set for them.' So, while she doesn't mind confronting issues with her children, and them knowing that she is angry and hearing it in her voice, she does try hard not to 'shout and scream at them', and

certainly doesn't believe in smacking them.

What about inhibitions? Anne believes that if her neighbours hear her 'going over the top' in terms of shouting or smacking her youngster they will report her to social services. She says this is one of the main things that makes her able sometimes to control her temper. Elaine believes that it is simply not right to shout and scream at young children, and certainly not to hit them.

In terms of response, Anne thinks that 'A good smack never did anyone any harm,' while Elaine believes that 'Adults hitting children is simply bullying.'

Beliefs and behavior

One of the interesting points raised by the example of Anne and Elaine is that it doesn't matter whether beliefs are right or not, they still influence the behavior of the person who holds them. For instance, Anne may be correct in believing that 'Kids do all they can to deliberately annoy you' and Elaine may be wrong in believing that 'Children are just selfish by nature and grow out of it eventually.' It really doesn't matter who is right and who is wrong: both are heavily influenced by their own beliefs. You sometimes even see the paradoxical situation where Elaine's child may be annoying her quite deliberately but, because Elaine believes what she does, she not only leads a calmer life but also sets a better example for her child.

Let's look at another example, this time involving flirting. Fiona and Graham live on a new housing development, and Graham has quite serious problems with jealousy. Hannah and Ian are another young couple who live nearby. Fiona and Hannah are good friends and are very similar in many respects. Unlike Graham, however, Ian has no problems with jealousy.

On several occasions Graham and Ian have faced more or less the same 'trigger'. From time to time both couples find themselves at the same party – in fact, very often they will actually all go to the party together. Both Fiona and Hannah are warm, friendly and extrovert young women who like to have an uninhibited time simply in terms of dancing, drinking and feeling the pleasure of having friends around them. Graham and Ian appraise these 'triggers' in quite different ways. Graham believes that if a woman is married then she shouldn't be showing any interest in any other man, and this is what he perceives Fiona as doing. Ian, on the other hand, believes that it is only natural for women to show an interest in men and vice versa. He simply believes that if you are married then 'You shouldn't take it any further than the interest stage.' So, as a result of the same events, Graham becomes angry whereas Ian doesn't. Graham's angry brain is recommending to him an angry response, whereas Ian's is not.

In terms of inhibitions, Graham believes that it is wrong to hit anybody, and certainly somebody you love, so even though angry he will not respond that way. (Interestingly, Ian is not totally averse to getting into fights; he does not believe that is totally wrong. Fortunately, however, he rarely becomes angry.) Graham also believes that if he 'addresses the issue head on' then (a) Fiona will think he is a 'wimp' for being jealous, and (b) this will put a damper on the fun they might have at any future party.

In terms of responses, Graham believes it is wrong to hit people so that is ruled out. He also believes it is undesirable to shout or to address the issue head on, so he tends not to do this. His beliefs about sulking, however, are not quite so negative; so

that is what he tends to end up doing. Ian, on the other hand, believes that 'Sulking is something women do,' so even when angry doesn't tend to respond like that.

It is clear from these examples that our beliefs can have an all-pervasive effect on us – not just on irritability and anger but on every aspect of our feelings and emotions: jealousy, anxiety, depression, anything you care to mention.

Beliefs and other people

Once a year my mother and I go off on two or three days' holiday, just the two of us (my family stays behind and has a bit of respite). A couple of years ago we found ourselves in Paris, in an extremely nice hotel which we could certainly never have afforded had it not been for a very special offer at the local travel agent. Anyway, once there, we look around for what to do. Tickets available from the hotel include an evening at the Moulin Rouge which is, as you know, a kind of review bar for tourists. It looks good, and of all the attractions on offer it is the only one we have heard of. The only snag is that it is expensive: 900 francs per person for the evening – that's about £80 or \$125. However, this (it seems) includes everything: dinner, drinks, review, the lot. So we sign up, and the next evening off we go. The Moulin Rouge consists of a big stage on which a lot of girls strut their stuff – and an even bigger area where about five million tourists eat their dinners at tables crammed more closely together than you have ever seen before. We are given a terrific table, right next to the stage, are given complimentary drinks shortly followed by the first course of our dinner, and sit back for a good evening. As the show starts, I notice a very small card sitting on the table, pick it up and just manage to read what it says in the gloom. My hazy brain does a slow translation: 'minimum drinks order 600 francs per person'. I am stunned. Not only having paid handsomely for our two tickets, we are now faced with having to pay another substantial sum for drinks. I am not even sure I have got that much money on me. Everywhere I look I see twenty-stone bouncers, and begin to realize the true meaning of the phrase 'tourist trap'.

My mother is pretty engrossed in the show. I am feeling sort of nauseous, and, even from the inside, can tell I must look glazed. The Third Act finishes and there is a gap before the band starts up to herald the Fourth Act. At this point I mention, calmly of course, that there is a card on the table that says there is a minimum drinks order of £50 or \$85 per person.

And this is where beliefs come in. Me, I believe that all big cities are the same and that if you go to a tourist trap then you expect to get trapped. My mother, she has had good holidays in France so, quick as a flash, she says: 'No, it's all right, the French are nice' – without taking her eyes off the stage. It is a simple belief, deeply embedded and has ramifications for a thousand and one situations that might arise in France. (And, thank goodness, she was right: the card's strictures didn't apply to us.)

Not long after the Moulin Rouge experience, I came across another example of an extended version of 'French people are nice.' I was walking along a promenade in a quiet coastal resort, and coming towards me was a man of about 25 who clearly had significant learning difficulties. He had a rucksack which was causing him some trouble: he had managed to get it properly hooked over one shoulder, but the other side was sort of pinning his arm halfway behind him. This posture will be familiar to anyone who has ever tried to put a rucksack on; and it's much more easily sorted out by someone else than by the wearer. So this man simply walked up and stood in front

of me without saying a word; and I sorted out his rucksack.

What does that say about this man's beliefs about other people? '*Other people are nice.*' So nice, in fact, that if you are having trouble with your rucksack, all you have to do is go and stand in front of a random person and he or she will sort you out. You don't even have to say anything!

So, not only do underlying beliefs influence just about every moment of your life; but doing a bit of work on your beliefs can pay off handsomely. We'll look at how to do this later on in the book.

Where do beliefs come from?

Some of you reading this might be wondering where our beliefs come from. Well, clearly they come from our experiences. Many of them come from early experience (our childhood, school and upbringing) and are never revised. Sometimes, for example, people are taught as children that everybody in the world is out for what they can get, so you have to watch your back. Others, although they are not explicitly taught such lessons, pick them up for themselves through observing others. Equally, many people are taught as children that 'people are basically good', or have had the sort of upbringing which has led them to believe that this is the case, whether or not it was spelt out for them.

On the basis of these 'mega-beliefs' we make rules for ourselves. For instance, if I believe that everyone is out for what they can get, I will have a series of sub-beliefs along the lines of 'I must keep my wits about me,' 'You have to watch everybody like a hawk or they'll take advantage of you,' and 'If you give someone an inch they'll take a mile.' Equally, if I believe that people are basically good I will have a series of sub-beliefs along the lines of 'We must trust each other in order to flourish,' 'The best place to relax is in the company of others,' and so on.

SUMMARY

- We set out in this chapter to answer the question of why a particular situation would irritate one person and not another.
- We came to the conclusion that it is to do with our beliefs about ourselves, other people, the nature of the world, how people are meant to behave and how we are meant to behave.
- These beliefs are developed over the years through our experiences and observations, often based on the things we are told when we are young.
- We found that our beliefs also underlie our inhibitions. Some people believe that you shouldn't ever hit anybody, even if it's called 'smacking'. Other people believe you mustn't hit anybody unless it's someone much smaller than yourself, like your child. Other people believe that it's wrong to shout. Other people believe that it's right to talk things through with people even if they are very young. Other people believe that to set a good example is very important. All these beliefs will form part of our internal inhibitions. Others are much more constrained by the likely results of their actions, so believe that it is ill-advised to pick a fight with somebody bigger than you, as you're likely to get hurt; these beliefs form part of their external inhibitions.
- People even have beliefs about the kind of responses it's okay to make. Some people believe that an obviously aggressive response is inappropriate, but sulking would be okay; and so on.
- All this knowledge about beliefs and their influence forms another important area that we will be able to use to our benefit when we come to Part Two of this book.

Why am I sometimes more irritable than at other times?

Up to now we've concentrated largely on the question, 'Why do some people get angry more easily than other people?' And we've come up with lots of answers – or at least, we could work out lots of answers for lots of different situations if we wanted to by going through our model. Some of the answers might be as follows:

- John gets more angry than Ken because John finds himself in more anger-making situations than Ken does.
- Laura gets more angry than Mona because Laura tends to judge and appraise situations differently from the way Mona does.
- Norma gets more angry than Olive because her inhibitions aren't so well developed.
- Pete seems to get more angry than Quentin because Pete will countenance more hostile responses than Quentin does. For example, Pete will shout and threaten while Quentin tends to sulk.
- Rachel gets more angry than Sarah because Rachel believes that other people are basically a self-centred lot who can't be trusted, so she tends to misinterpret some situations.

And so on.

So, we can now make some more informed and reliable judgements about why some people get more angry than others, or seem to be more angry than others (because of the way they respond when they are angry). And this is good, because if we want to be one of those people who is angry less often we can already see that there are going to be some very powerful things we can achieve. We have a nice model which we can apply systematically in your own particular case.

Moods

But for many people it is the *variation* in their irritability that really concerns them: in other words, some days they feel really irritable, other days they don't. If you are one of these people then you will know that this variation causes major problems for people around you, because they never know 'what mood you're going to be in'. So they can never relax properly with you, and that in turn means that the feelings of intimacy and closeness that would otherwise develop between you and them simply don't have a chance to take root.

Moreover, you will also know that this causes major problems for yourself – not just in how it impairs the intimacy of relationships, but also because you continually

feel as though you have ‘let yourself down’. If you have these big variations in irritability you will sometimes look back on things you did yesterday, or even earlier on today, and feel embarrassed or ashamed by them. For, although they seemed perfectly sensible and justifiable at the time, now you can see that you were being excessively irritable – you were in ‘a bad mood’. (Actually, they don’t always seem that sensible at the time; maybe you know when you’re feeling irritable, and that’s a very bad feeling. The trouble is that it seems very difficult to ‘snap out of it’ at the time, and indeed it is.)

The good news is that there are all sorts of things that we can do to keep ourselves in a ‘stable mood’. But first we need to focus on the key concept of ‘mood’.

In terms of our model, like ‘Beliefs’, it influences all four of the major boxes from ‘Appraisal/Judgement’ downwards, so that the model now looks like Figure 7.1.

How does this work? First of all, take the way mood influences the way we appraise and judge things. Try thinking of Tim, who does indeed have problems with his moods and who will see things quite differently depending on whether he’s in a good mood or a bad mood. He drew up a table to show just how differently things could look to him (Table 7.1).

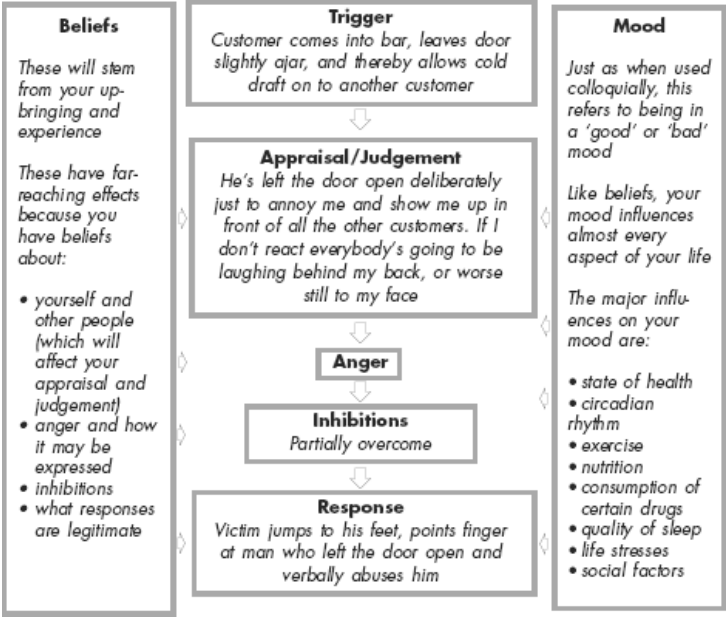


Figure 7.1 A model for analyzing irritability and anger

TABLE 7.1: GOOD MOODS AND BAD MOODS, 1

Situation	How Tim sees things when he's in a good mood	How Tim sees things when he's in a bad mood
Neighbours playing music next door	Cheerful and symbolizing the cheerfulness of life	Selfish and inconsiderate
Neighbours' children playing football in the street	Communal thing to do; sometimes Tim would even join in	Selfish and inconsiderate; Tim will watch for the ball going on his garden
People coming into the pub when Tim is sitting near the door	'The pub filling up nicely' – regardless of whether they shut the door or leave it open	Thoughtless and a nuisance
Tim's wife contradicts him in public	'A chance for a good bit of banter'	'Totally out of order'
Sees his wife flirting with other men	'All good fun – there's nothing in it'	'Totally out of order'

Uma has exactly the same problem with her moods, and she constructed a similar table (Table 7.2).

TABLE 7.2: GOOD MOODS AND BAD MOODS, 2

Situation	How Uma sees things when she's in a good mood	How Uma sees things when she's in a bad mood
Her husband eating noisily	Doesn't notice	'Totally unbearable'
Her children dropping and breaking things	'Accidents will happen – I've broken enough things myself in my time'	'Drives me completely mad – it's just pure carelessness'
Waiting for two hours in an outpatient clinic with her child	Likely to see it as a chance to get to know the other mums	Storms straight into the clinic room and has it out with the doctor there and then
Her husband 'telling all and sundry what they've been talking about'	Never takes a positive view of her husband talking about things she had regarded as 'between them'; however, 'best just to leave it'	'The last straw – I just feel like walking out on him at that very moment'
Children are disobedient	'It's no use getting het up about what your kids do, there's no changing them'	'I wonder why I ever had them'

It's clear from these few examples that anybody who is in a remotely similar situation to either Tim or Uma will be having a great deal of trouble making sense of their life. One day they're up, the next day they're down. One day they're laughing and joking with people; another day they're snapping their heads off. Worse than that, it can vary from one half-hour to another. So what kind of things do we have to watch out for to keep our mood steady? Some of the main factors are:

- **Illness:** mental illnesses (such as depression) or physical illnesses (such as viral infections) can both disrupt your mood.
- **Routine:** it is very important to maintain a fairly consistent routine in terms of times of eating and sleeping, to maintain a steady 'circadian rhythm'. Otherwise you find yourself in a permanent state of 'jetlag', which is very disruptive.
- **Exercise:** humans are built for activity, and during phases when we don't get this we are liable to be that much more irritable.
- **Diet:** some people eat lots of sugar-rich food which sends their blood sugar level sky-high and

then correspondingly low. Other people feed themselves so poorly that they are effectively suffering from malnutrition.

- Drugs: routinely consumed drugs such as caffeine, alcohol and nicotine are vastly underestimated in their effect. Recreational drugs can also devastate one's mood.
- Sleep: getting insufficient sleep on a regular basis is bad news indeed.
- Stress: having too much to do, too many pressures on you, tasks you find difficult to achieve, and other life stresses take a severe toll on your moods.
- Social factors: arguments with friends, relatives and workmates; bereavement, separation and divorce; simply feeling lonely – these are just some of the social factors that can affect our mood.

If you know that you sometimes get irritable, the chances are that there are several items on that list which look familiar to you. The good news is that we can work on them, and later on in Part Two of this book, we will see exactly what to do.

There are tremendous pay-offs here. Most people much prefer someone who is 'the same every day' to someone who is 'downright moody'.

Case study: Georgina

Georgina went through a period of three years in her late teens when, she said, she would 'snap anybody's head off who looked at me in the wrong way'. It turns out this wasn't quite true; there were just some days when she acted this way. Other days she was a thoroughly agreeable young person with lots of friends, a nice family life and occasional boyfriends. It turned out that the reason she was sometimes so irritable is that she was prone to get quite depressed, mainly on account of her boyfriends being only 'occasional'. When she did feel depressed, however, she was snappy in the extreme, and even people's attempts to cheer her up provoked an abrasive reaction. Unsurprisingly, some of her friends drifted away, while even the ones that remained tended to treat her with some caution.

The solution to Georgina's problems was twofold.

- First, she gradually worked on her depression until she settled in a fairly consistently happy mood. This was difficult, because she had set up a vicious circle whereby her depression caused her irritability, which caused some of her friends to desert her, which in turn exacerbated her depression. Nevertheless, she implemented three significant measures which helped her to be happier.
- Second, and while she was working on her depression, she also worked on the 'Response' box in our model. In other words, she trained herself to 'button my lip and count to ten' whenever she felt like snapping.

The net result is that both she and her friends feel that life is now more predictable and, partly as a result, more rewarding.

SUMMARY

- Sometimes you may be more irritable than at other times. One day you may be in a good mood, the next in a bad mood. The key concept here is 'mood'.
- There are lots of factors that influence our mood, notably illness, routine, exercise, diet, drugs, sleep patterns, life stresses and social factors.
- We can work on these (as we shall see in Part Two) so that, if we want, we can be not only difficult to anger, but reliable and consistent: 'the same every day'!

Is it always wrong to be angry?

Briefly, the answer is 'no'. However, perhaps it is always wrong to be irritable.

Why is it not wrong to be angry? Simply because the question of whether anger is 'wrong' or not doesn't really arise. Rather like gravity, anger is part of life; so to start questioning whether it is good or bad is to head up something of a blind alley.

This is not the whole story, however. Perhaps we can give a better answer by asking what purpose anger serves. Most of the things that are 'part of the human condition' do serve a purpose and one suspects that anger is no exception.

Anger and disapproval

One purpose is to help to produce 'socialization' in other people: in other words, to encourage other people to behave in the way we would like them to – or, more accurately, to discourage other people from behaving in a way we don't want them to. The distinction is not just a question of semantics. It *is*, in fact, possible to influence a person's behavior much more by encouragement than by discouragement. This point was encapsulated by the old cartoon depicting a fearsomely old-fashioned school with a notice on the wall reading 'the beatings will continue until morale improves', neatly making the point that some things simply cannot be produced by beatings – or anger, or any other negative means. Nevertheless, for our present purposes it is worth noting that anger does indeed serve a function of discouraging behavior that we don't want.

The trouble with this is that if we happen to be rather intolerant individuals, then we can feel there is a tremendous lot of 'behavior we don't want', which in turn means that we will spend an awful lot of our lives being angry. (In this context the concept of 'zero tolerance' seems to me a disastrous one. For the state to discuss, advocate and encourage a principle of 'zero tolerance' seems doomed to produce adverse consequences across the board.

On the other hand, if we ourselves are fairly tolerant individuals, and know what behavior we like and dislike in each other, then anger can be a highly appropriate response, though of course in moderation. Maybe 'anger' is not really the right word in this context; possibly 'annoyance' is nearer the mark. If somebody cares for us and cares about what we think, then to see that their behavior has annoyed us even slightly would be sufficient to influence them.

One piece of good news is that there is much less undesirable behavior than we think. Take the case of Walter and Yvonne, who were out for a day trip to the seaside

with their children aged ten and twelve. It was 12.30 p.m., just coming up to lunchtime, when the family was walking past an ice-cream van near the beach. The ten-year-old asked for an ice cream, to which his father replied: 'No, it'll be lunchtime in a quarter of an hour.' The boy was not to be pacified, however, and persisted in trying to persuade and cajole his father to buy an ice cream, refusing even to move on past the van.

His father's response was to insist: 'If I say no, I mean no. If you really want one, then you can have one after lunch.'

This was no good; the ten-year-old wanted his ice cream there and then, and achieving this was evidently becoming more important than life itself. His father, for his part, felt that it was important to make a stand and show his son that you can't always have what you want.

Well, I will spare you the ghastly details, but suffice to say that that was the end of their day trip as any sort of enjoyable enterprise.

I talked to Walter about this afterwards in terms of the personality characteristics being displayed by the ten-year-old boy. What it boiled down to was that he was being very assertive and very persevering, both of which characteristics his father thought were admirable ones he'd want in his son when he became an adult. So, paradoxically, he felt he should be encouraging such characteristics rather than just getting angry when they are displayed!

This is only one small example of how tricky it can be to judge and appraise situations. Much more often than it seems at first sight, the characteristics that are being displayed when we are tempted to get annoyed are ones which, in other circumstances, we would actually value rather than condemn.

What it boils down to is that anger – or at least annoyance – can be entirely appropriate to express disapproval of other people's behavior, *when we really are sure that we disapprove of it.*

Anger and motivation

Anger/annoyance also has another purpose, namely to provide us with the motivation to do things we otherwise wouldn't do.

One of the angriest times I have ever experienced was when our nine-month-old daughter got locked in the car on a very hot summer's day, with the keys also in the car. Nearby was a man from the emergency rescue service who wouldn't help us in spite of our being members.

It was the middle of June, Amelia was in her buggy on the back seat of the car, and my wife had inadvertently locked the keys in the car. Distraught, she left Amelia and the car and went out on to the street, with our other daughter who was two, to seek help. As if the gods were really with her, she spotted a man wearing the uniform of the rescue service just fifty yards down the street. She explained her plight, to which the man replied 'Are you a member?'

Patricia said yes, she was, to which the reply was: 'Have you got your membership card?'

Patricia said: 'Yes, it's in the car.'

And the man's response was: 'Well, I can't do anything without your membership card.'

However, in a fit of generosity he loaned her a coin to phone me up so that I could

come with the spare keys. I got there as quickly as I could, gave Patricia the spare keys and went to speak to the 'rescue' man.

I say 'speak to', but that is perhaps misrepresenting what followed. I gave him a full and thorough account of what I thought of him and his family, lasting a good five minutes and much to the entertainment of passers-by.

Now, if you had asked me one sunny June afternoon to go and advise a representative of a road rescue service on how he should behave if somebody has locked themselves out of – and their baby into – a car, I would probably have said that I had better things to do. It was only the absolute rage I felt that fired me up to enthusiastically advise this particular man.

The same thing applies when we hear stories of people going to help strangers beaten up in the street, or countries declaring war on other countries that are trampling over the human rights of their neighbours.

How much anger is enough?

So, the interesting question arises as to how much anger we need to display in order to influence other people's behavior. Clearly, there is a vast range available. As we said earlier, if a person cares about you and what you think, then your expression of the slightest hint of annoyance will probably be sufficient.

In fact, different rules hold good for physically violent situations such as war. So, for the moment, let us confine ourselves to non-violent interpersonal situations.

With anger, as with most other things, it is not a question of 'the more the better' if you want to be effective. The inverted U-curve, sometimes known as Aristotle's golden mean, holds good here. If you like graphs, this is the thing for you. It is normally drawn as shown in Figure 8.1. It suggests that a little bit of anger will have some effect; a bit more anger will have more effect; but if you increase the anger too much, then the effect comes down again.

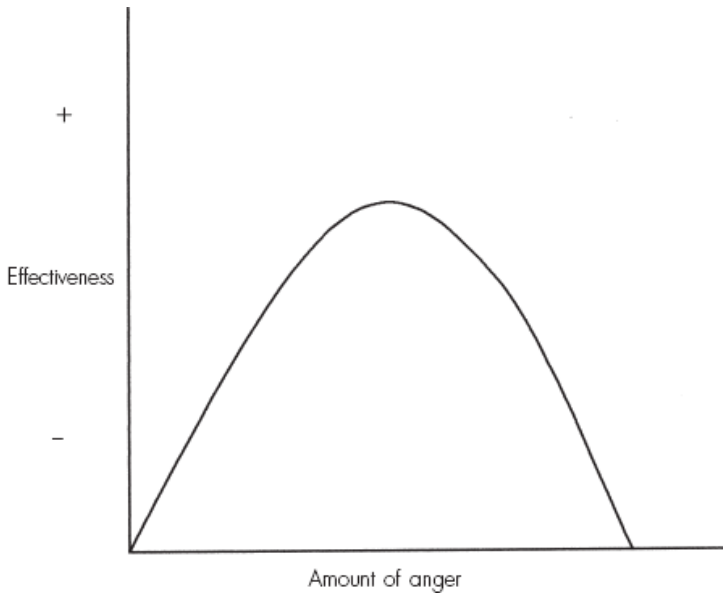


Figure 8.1 The traditional inverted U-curve

Actually, this 'traditional' inverted U is not quite what is needed in the case of anger. More accurate is the version shown in Figure 8.2. What this shows is that the 'best' amount of anger is just a small amount. If you increase it, the effectiveness decreases. And if you increase it even more, then the effectiveness is negative; in other words, what you are doing is counter-productive, and, far from influencing your target in the required direction, will provoke them to 'dig their heels in' or 'react against you', or however you like to describe it.

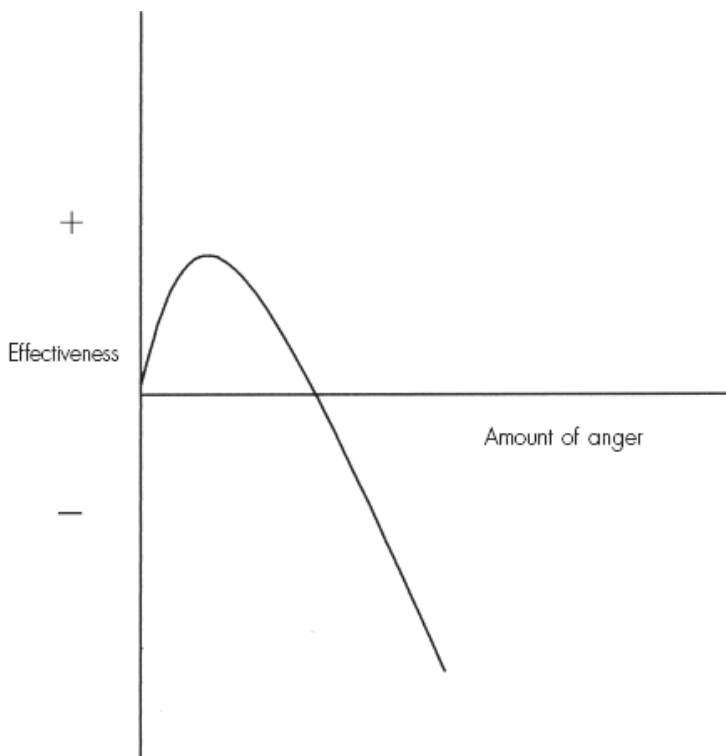


Figure 8.2 Graph showing effective anger

If you don't like graphs, forget this and think about someone who's not very good at making a cup of coffee. For the sake of argument, let's agree that the best amount of coffee to put in a mug is one rounded teaspoonful. So Andy comes along, puts two rounded teaspoonfuls in his mug, adds boiling water and milk, sits down to enjoy it and finds it doesn't taste very nice. Of course, he doesn't know *why* it doesn't taste very nice because he's no good at making coffee. So what does he do? He goes and puts in a third teaspoonful, which, of course, makes it taste even worse. And if he's really hopeless, he may even go back and add a fourth.

Now, the coffee example seems ridiculous to most of us because we know how much coffee to put in a mug. Not to Andy, though, because he's never made his own coffee before, and he has no idea how to do it. This is an exact parallel with some people and their anger. They start off by displaying much too much anger and find that they don't get the desired result. So what do they do then? Get even angrier still. To an onlooker this is as bizarre as Andy putting even more coffee in his mug when he already has too much. To the person concerned, however, it doesn't seem like that. 'If that much anger didn't work, then perhaps twice as much will,' they seem to be saying.

In summary, anger, like pepper, is best in very small amounts, if at all.

Does irritability have a purpose?

What about irritability? Does the same argument hold good there? The answer seems to be ‘no’, because the essence of irritability is that it is unjustified and inappropriate – more a reflection of your mood than of anything anybody else has done.

I have heard it said that the advantage of being known as ‘irritable’ is that it keeps everybody else ‘on their toes’. The implication is that you will always be treated as carefully as though you were at your most irritable, because even when you are in a good mood people put it down to the fact that they are ‘handling you with kid gloves’. So they carry on treating you that way.

For most people this has only a superficial attraction. Most people want to be respected and liked at work and in social situations, and liked and loved at home. While irritability may force others to *cover up* the manifestations of their disrespect and dislike for you, it does no more than that. There seems no shortcut to acquiring respect, liking and love, short of earning it. Being irritable normally means starting off with an overdraft.

SUMMARY

- Anger is okay in the sense that most people get angry at some times; it’s something we have to live with.
- Nevertheless, it does seem that we can influence the behavior of those around us much more by positive means than becoming angry.
- Even so, anger – or at least annoyance – is a reasonable way of expressing displeasure at what somebody else does.
- In terms of *how much* anger is appropriate, it is almost always *a lot less than we think*. Indeed, too much anger is not only ineffective, it is distinctly counter-productive.
- Irritability is never justified. After all, it is *defined* as ‘unjustified anger or irritation’!

PART TWO

Sorting It Out

Part Two of this book is all about solutions.

Having read Part One, you now know a lot about irritability and anger. However, knowing about a problem is not the same as solving that problem. So in this part of the book we examine all the possible solutions.

There are several ways of reading this part. Each chapter title gives you a pretty good idea of what is in the chapter and why you might want to read it. So you can, if you want, go straight to the chapters you think are most relevant to you and read those first. In fact, you will find it works even if you *just* read those, and omit the others. You can ‘pick and choose’.

Alternatively, you can read steadily from here to the end, including every chapter whether or not it seems relevant at first sight. This isn’t a bad idea, because some of the content may turn out to apply to you even though it might not have looked like it on first consideration. I have tried to include lots of examples (there are twenty-four, in fact), and some of them come up repeatedly; you might well find that you can easily identify with some of these cases.

At the end of each chapter is a summary and a project (or more than one!) to do. It is those projects which are really going to make a good impact for you if you follow them through.

Whichever way you tackle this part of the book, I hope you find it useful.

Getting a handle on the problem: The trigger

If you think back to Chapter 4, where we were starting to work on the model of irritability and anger, you may remember that the most basic model looked like Figure 9.1. This diagram doesn't contain all sorts of boxes that we added as the model developed, but does contain three of the most essential ones. We can see that if any one of these three boxes is altered, then the whole sequence of irritability and anger comes to an end.

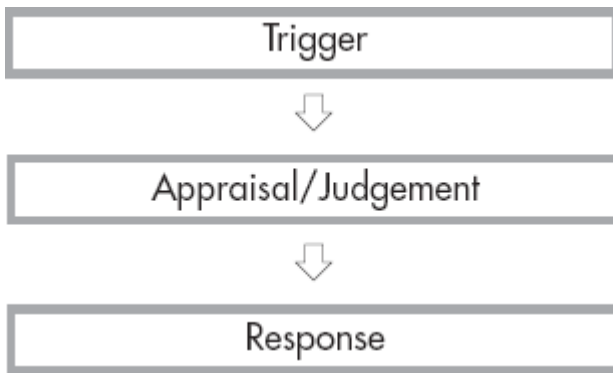


Figure 9.1 A model for analyzing irritability and anger

For example, take Gerry, whose trigger is his neighbours playing music too loud. If that trigger doesn't happen, then the irritability and anger don't happen. Equally, even if the trigger does happen (the neighbours play their music), he still won't respond with anger if he appraises it as 'just them having a bit of fun – the thing to do is live and let live.' And finally, even if the trigger does happen and he appraises it as 'those awful people again – they need a good sorting out,' he will still not display any irritability and anger if he takes himself off to see his friend in the adjoining road or puts his own earphones on.

So, this simple model yields three possible solutions:

- 1 somehow or other have the neighbours not play their music;
- 2 appraise it in a different light; or
- 3 respond in some different way.

In this particular example, which would you say is the best solution? Personally I'd go for either number 1 (ideally) or number 2.

Or what about Anne, who said she completely 'lost it' when she found her twelve-year-old daughter washing her hair in the bath instead of tidying her room? Again, there are three possible options:

- 1 she could have somehow got her daughter to tidy her room (we'll go into how later on);
- 2 she could have appraised it a different way ('Well, at least she's keeping herself clean'); or
- 3 she could have responded in a different way, for example by taking herself off, calming down, and telling her daughter (again) that she expected her room to be tidied after she'd finished her bath.

Again it's a matter of personal opinion, but possibly numbers (2) or (3) would be the front-runners in this case.

And what about Steve, who gave a good roasting to the fifth guy who left the bar door open? In that case he could have

- 1 removed the trigger (by moving to a different table after the first couple of times);
- 2 appraised it differently ('There are worse things in life than having to push a door closed every twenty minutes'); or
- 3 responded differently, perhaps by asking each person to shut the door.

Possibly either (1) or (3) might be better in this case.

So, even with a simple three-box analysis some reasonably good solutions present themselves.

The odd thing is that in each of these cases the individual concerned had taken on a sort of 'victim role', as though they could do nothing about what was happening. So Gerry blamed the neighbours ('What can you do if you've got neighbours like that?'), Anne told the story as just one more example of how 'difficult' her daughter was, and Steve saw his experience in the bar as one more example of how 'ignorant' other people are.

Keeping a diary

In fact, there's no need to be a victim: there are lots of things we can do once we have 'got a handle on' the problem. In other words, *once you know, reliably, what triggers your anger or irritability you are halfway to sorting it out*. And really to get to know what triggers it, you have to keep a diary.

The best form of diary to keep, in the first instance, is illustrated by Diary 1. You will see there are just two boxes: one for you to write about the trigger, and the other one for you to write about how you responded. There is one blank copy of this diary included here, and there are ten more in the Appendix (pp. 278–85).

These diaries are very important indeed. Their function is, as I've just said, to enable you to get a handle on what makes you irritable and angry. If you can do this, you are halfway home. So exactly how do you fill them in? The answer is: it is best to fill in a diary sheet each time you get irritable or angry, and to do it *as soon as*

possible after the incident. It is also a good idea to make your accounts as complete as possible. On the following pages I have reproduced more or less what was filled in by several people we have already described, when they kept their diaries.

Diary 1

Keep a record of when you get irritable or angry. Fill it in as soon as possible after the event. Note as clearly as possible what triggered your irritability/anger, and how you responded

TRIGGER (INCLUDE DAY, DATE AND TIME)

RESPONSE (WHAT DID YOU DO?)

Example (a)

TRIGGER (INCLUDE DAY, DATE AND TIME)

Saturday 3 June, 11.15 a.m. The kids next door were playing football in the street outside. They had already been across the lawn several times and finally the football hit our front window.

RESPONSE (WHAT DID YOU DO?)

I went straight out, took the ball off the kids, rang the bell next door and gave their mother a piece of my mind.

Example (b)

TRIGGER (INCLUDE DAY, DATE AND TIME)

Friday 28 February, 9.30 p.m. Several people had already come into the bar and left the door open. We were sitting just by the door, three of us, and it was very cold outside, so there was a draft when the door was left open. None of them gave a damn about us, just marched straight in and went up and got their drinks. It wasn't until about half a dozen people had done this that I reacted.

RESPONSE (WHAT DID YOU DO?)

To the first few people that came in I didn't do anything. But when the fifth guy came in I just got up and threatened him. I stood in front of him and told him exactly what I thought of him and his type so that the whole bar could hear. That was pretty much an end to the evening. The other two didn't really get settled again and we went home after about half an hour.

Example (c)

TRIGGER (INCLUDE DAY, DATE AND TIME)

Tuesday 3 June, 8.00 p.m. We were sitting, eating a meal when, yet again, my husband was chewing his food so loudly that half the street would be able to hear him. I'm sure he does it just to annoy me, or at least he doesn't care that it does annoy me. What he does is to get his mouth full of food and then spend ages chewing every mouthful and talking to me while he does it.

RESPONSE (WHAT DID YOU DO?)

I didn't say or do anything, I just felt really tight inside. And I didn't talk to him properly and I just felt sad being married to him. I've told him about it dozens of times before, so what's the point going on about it again? But somehow it just symbolizes the way he is – he doesn't care about me, just about him.

Example (d)

TRIGGER (INCLUDE DAY, DATE AND TIME)

Wednesday 17 September, 5.30 p.m. Ian, who is 13, dropped a coffee mug on the kitchen floor and it shattered. There was no coffee in it, just the mug – but that's typical of him. He just doesn't care, he thinks money grows on trees and anything he breaks I will replace.

RESPONSE (WHAT DID YOU DO?)

I completely lost it. I shouted at him and told him to get out of my sight. It took me a good half hour to one hour to calm down at all. Even when he was upstairs I went up and told him again.

Example (e)

TRIGGER (INCLUDE DAY, DATE AND TIME)

Wednesday 7 June, 3.30 p.m. The boss asked me to go out to Scudamore Avenue to sort out a call there. The occupier wanted some wiring looked at that they weren't sure was safe. The thing is that the boss knew I already had plenty of work on and he was just taking advantage of me because he knew I wouldn't complain.

RESPONSE (WHAT DID YOU DO?)

I was just very short with him so that he would know I was irritated and thought he was out of order. But I finished off the work that had to be done in the base and then went off and sorted this other person's wiring out. And I did the jobs properly.

Example (f)

TRIGGER (INCLUDE DAY, DATE AND TIME)

Thursday 10 April, 6.30 p.m. I had been on at my daughter all day long to tidy her room and she kept saying she would do it in a minute, or a bit later. Then at about half-past six I found her sitting in the bath just washing her hair – and deliberately provoking me, saying, 'What are you going to do about that then?'

RESPONSE (WHAT DID YOU DO?)

I really let rip. I shouted and screamed at her for – it must have been ten minutes. She went really pale, and looking back at it I was over the top. But it worked, she did tidy her room later on.

Example (g)

TRIGGER (INCLUDE DAY, DATE AND TIME)

Wednesday 27 July, 4.15 p.m. There was no real trigger beyond the fact that I was feeling very stressed out, as usual. At work these days there are just so many demands on me from so many different people that I cannot possibly fulfil everything that everybody expects of me. Therefore, when Phil just made some throw-away remark, that was the last straw.

RESPONSE (WHAT DID YOU DO?)

I just blew my top at Phil and criticized him for his attitude. It was totally unfair, what he had said was just by way of banter. Me blowing my top was much more to do with my state of mind than Phil's attitude. But anyway I apologized to him later on and things seem to be okay now, more or less.

Reading your diary

Well, never mind reading your diary for the moment. Let's first of all get good at reading other people's diaries.

Even before that, let's recap on what the point of reading these diaries is: it is *to obtain insight into what makes you irritable and angry, so that you can take action about it*. And, to do that, you will first of all have to develop the skill of reading diaries astutely.

Now let's take the examples in order.

First of all, look again at example (a), in which Colin tells how he was driven to distraction by his neighbour's kids playing football in the street. Which of the following possibilities do you think was the trigger:

- 1 the kids repeatedly running across his grass;
- 2 the football hitting his window;
- 3 the thought that his neighbours showed no consideration for him;
- 4 the belief that kids playing in the street makes the area look poor?

In this particular case the answer Colin gave was both (1) and (2); but what really irritated Colin was that the neighbours had no consideration for people around them, and indeed made the street look like a rough area. So in a way Colin's anger had more to do with his appraisal and judgement of the trigger, rather than the trigger itself. Nevertheless, if he wants to sort out his irritability and anger he needs to spot the 'visible' trigger of the boys playing football. Once he knows this is his weak spot, then he can sort out how to re-appraise it, if that is what he decides on.

If Colin wanted to become less irritated and angry, he could view the children playing outside in a different light. He could view it simply as 'kids having a good time' and 'showing that the street is a lively place to live'. Do you think that is likely to work with this man? No, neither did I.

So what is left? In this case, the main thing is to look in the response box. If you recollect, his response was to take the ball from the kids and storm round and shout at their mother. What other response do you think he might have made? Which of the following do you think would be best:

- 1 switch on the television, turn the volume up loud until their game is over;
- 2 every time the kids appear on the street, go round to their mother and put his point of view in as friendly a way as possible;
- 3 do nothing, just blank it all from his mind?

I would suggest that option (2) is the best one: to go round and put his point of view, amicably, just as often as he likes – preferably, from his point of view, just as soon as the kids appear on the street.

Many angry and irritable people make the mistake of thinking that the best reaction is (3), to ‘do nothing at all’. This is not necessarily the case, particularly if you think that you are legitimately aggrieved. In such cases it is only right to stick up for your rights, assertively. But ‘assertive’ does not mean ‘angry’ or ‘aggressive’.

So, in example (a), perhaps the best bet is for Colin to alter his response; and this is what he did. Nevertheless, the starting point was for him to be clear about what triggered his anger, rather than just thinking he was generally bad-tempered.

What about example (b), where five people, one at a time, came into the bar and left the door open behind them? They came at roughly 15–20-minute intervals and, finally, Steve got so angry that he confronted person number five.

So what was it that really triggered Steve’s anger? There are several possibilities; which one do you think is most accurate:

- 1 the door being left open and the consequent cold draft;
- 2 the expression on the fifth man’s face, being so self-centred and not caring about the cold air coming in;
- 3 Steve’s perception that he was being made to look foolish, having to get up all the time to shut the door that somebody else had left open;
- 4 Steve’s perception that he was not being given enough consideration by these other people?

Here, the literal trigger is (1), the door being left open and the ensuing blast of cold air. That – possibly in conjunction with the expression on the person’s face – led to Steve’s appraisal that he was being made to look foolish, that he was not being shown enough consideration.

So what could he have done to get rid of the trigger? (After all, getting rid of the trigger is normally what we want to do. If we can get rid of the trigger it stops the whole thing snowballing.) Which of the following would you recommend:

- 1 move to a different part of the bar, away from the door;
- 2 don’t look at the person’s face, so it doesn’t annoy you;
- 3 realize that you are not being made a fool of;
- 4 don’t worry about whether people are showing you consideration or not?

There is an argument in favour of each of these; which one(s) did you choose? Personally, I would go for number (1), even though it’s not very ‘psychological’. There are some things that most people would find irritating, and sitting by a door that people keep leaving open is probably one of them.

But what do you do, I hear you saying, if there are no other seats in the bar? In that case we have to look at the response. How did Steve actually respond? He jumped up and behaved in a threatening way to poor old person number five, having said nothing at all to the previous four people. So what might have been a better response? Maybe he should have just asked each person coming in to shut the door, in a non-aggressive way? We will look at this again later.

Now, you may have noticed that this bar example is rather different from the previous one. You may feel that there’s more point in discussing the neighbour example, because that is an on-going situation which keeps happening every day or

every week, and it's a good one to sort out a solution for. With the bar example, we seem to be harking back to something that's over and done with, so what's the point in going through it all over again?

The answer is that you can get so good at analyzing situations that you analyze them automatically, even as they're happening. So, whereas Steve may not find himself in an identical situation again, sitting right by a bar door that people keep leaving open, he may find himself in a somewhat similar one. In that case, if he has worked out a way of dealing with it, he will be able to analyze it even as it's going on and, hopefully, act in a better way.

What about example (c)? This was the case of Pam, who is so acutely annoyed by her husband when he eats noisily. Again, what do you think was the 'real' trigger for her annoyance:

- 1 the sheer decibel-level of her husband's eating – he should learn to eat more quietly;
- 2 the fact that he carried on talking to her while he was still chewing;
- 3 the fact that she saw it as symbolizing their incompatibility;
- 4 the fact that she had nothing better to do than worry about how much noise her husband made when he was eating?

Numbers (1) and (2) are the literal triggers. So how could we remove them? Earplugs to cut down the decibel-level won't help. Talk to him while he is chewing so that he isn't tempted to talk while chewing? Perhaps not.

Really, the problem lies in Pam's appraisal that the chewing symbolizes their incompatibility. So, ultimately, it is either that – or their incompatibility itself – that needs working on. Nevertheless, she does need to be clear on the initial trigger so that she can take action on it. In the interim she might also ask him to chew a bit more quietly. But that would probably be missing the point.

The next example, (d), involved Sue's teenage son Ian, who dropped a mug on the floor and broke it. Again, what was the trigger:

- 1 the mug breaking;
- 2 the cost of the mug;
- 3 the loud noise the mug made when it hit the floor;
- 4 Sue's appraisal that Ian is careless and needs to be taught a lesson?

Well, number (1) is obviously the 'literal' answer, but it is quickly followed by number (4). Clearly, once Sue knows what the triggers are for her thinking like that ('he is careless and needs to be taught a lesson') she can prepare a more helpful appraisal and train herself to use it at such times. (Such an appraisal might be: 'We all drop things on the floor from time to time, youngsters especially. There's no need to get uptight about it.')

So, what have we got so far, from looking at these first four examples?

- It is sometimes quite difficult to see exactly what the trigger is, because the 'literal' trigger and the appraisal are jumbled together.
- It is worthwhile disentangling these two aspects, because then you can prepare a more helpful appraisal if need be, and be ready to use it next time the trigger for your irritation and anger appears.
- Keeping a diary, on the model of Diary 1, is helpful in doing this.

- Often the key lies in learning a different response, for example tackling the neighbour in a different way, asking people to shut the door, tackling the underlying issue of compatibility, telling the youngster to brush up the broken mug. But the same argument applies; before we can prepare a more helpful response, we need to be clear about what triggers our irritation and anger.

Let's move on now and have a look at the other examples.

The fifth one, (e), was about Alan, the electrician who was asked to do too much by his boss. What was the real trigger:

- 1 being overloaded with work;
- 2 feeling he is being put-upon by his boss?

Clearly the literal trigger is being overloaded with work. Feeling put-upon by his boss is the appraisal Alan makes.

In example (f) Anne lost her temper with her twelve-year-old daughter who was washing her hair in the bath.

What was the trigger for her anger:

- 1 the sight of her daughter in the bath;
- 2 the fact that her daughter hadn't tidied her bedroom;
- 3 the fact that she felt her daughter was being defiant;
- 4 the sense of frustration that she wasn't bringing her daughter up very well?

You will notice that a fourth option has crept in here that has got nothing to do with baths, tidy bedrooms or anything else. And this is sometimes the case. For example, some people will fight and argue simply because they are 'bored' or 'frustrated' or whatever. So in this case it is a possibility that Anne's anger has more to do with the frustration of wondering whether she is bringing her daughter up well than anything else.

In fact, frustration in general is frequently a trigger for anger or aggression, as was discovered by Miller and his colleagues back in the 1930s: a finding published as the 'frustration-aggression hypothesis'.

So what was your best answer as to what the trigger was for Anne? Possibly it was a mixture of frustration (partly to do with whether she is bringing her daughter up well, partly to do with her inability to get the girl to tidy her bedroom) and just seeing her daughter sitting in the bath when she wanted her to be doing something else. Her perception of 'defiance' is more an appraisal, following on from the trigger.

And our final example, (g), was to do with Ken, the stressed-out executive. What was the trigger for his irritability:

- 1 trying to cope with more work than he could reasonably do;
- 2 his colleague Phil being tactless;
- 3 just being in a bad mood that day?

From his account it sounds as though it was a combination of all three. Certainly he was overloaded with work, so he was in 'a bad mood'; but also perhaps the colleague was a shade tactless. Triggers can sometimes be slightly complex, as in 'my colleague being tactless when I'm overworked and in a bad mood'. Quite possibly none of the three elements mentioned (tactlessness, overwork, bad mood) would cause him to be irritable *on its own*.

Reading your diary (again)

The previous section will have got you pretty good at reading diaries in general – which means that you are also going to be pretty good at reading your own.

So all you have to do now is keep a diary of most of the times you get irritable and angry, along the lines described. Then analyze it to determine your triggers.

What you are looking for is a (short) list of triggers for your irritation and anger. Here are some that other people have produced:

- the neighbours playing loud music
- the kids next door playing football in the street
- the people next door showing no consideration for their neighbours
- other people being inconsiderate (as in the bar door)
- other people putting themselves above me (as in queue-jumping)
- my husband eating his food noisily
- my husband
- my wife
- my children
- my partner
- George, at work
- my son being careless
- being kept waiting
- being contradicted or proved wrong in public
- being overworked by my boss
- being dumped by my boyfriend
- my partner telling other people about things which were just between us
- my wife flirting with other men
- being made to look foolish in public
- my daughter being lazy
- my daughter being disobedient
- my son telling lies
- people stealing from me or damaging my property
- bouncers
- policemen
- being carved up by another driver
- being crammed in the tube
- being stressed out
- being bored
- being tired

SUMMARY

- It is important to have a very clear idea of what triggers your irritation and anger.
- Once you have that, you can either remove the trigger (although this is frequently impossible) or take a range of other actions, which we will cover later on.
- The best way of identifying what triggers your irritation and anger is to keep a diary; simply trying to recollect what triggers it is surprisingly unreliable. A good diary form for you to use (Diary 1) is included here.
- When you keep your diary you will find that you sometimes confuse triggers with appraisals (for example, writing the trigger down as '*half a dozen selfish so-and-so's down the bar*' rather than '*half a dozen people coming in and leaving the door open*'). Nevertheless, this can be helpful because, once you come to make your final (short) list of what triggers your anger, you may decide that the 'real' trigger is indeed 'other people's selfishness' rather than 'doors being left open'.
- A list of the triggers that other people have found for their anger is given above; this may be helpful as a starting point when compiling your own.

PROJECT

- Probably by keeping the diary (Diary 1), get a crystal clear idea of what triggers your irritation and anger. It may be specific (people leaving the lounge door open) or diffuse (my son being careless – which could be manifested in lots of ways), external (someone else doing something, e.g. dropping a mug on the floor) or internal (within you, e.g. being bored, being tired). However you do it, become an absolute expert on what makes you irritable or angry, so that if someone were to ask you, you could give them a vivid description of what does it for you.
- If possible, remove those triggers. You will find that this is surprisingly difficult. Some triggers can be removed, others cannot. Don't worry in either case. The following chapters will show you what to do if the trigger can't be removed. Nevertheless, if you can easily get rid of it, do so.

Why do I get angry?

1: Appraisal/judgement

What you will learn in this chapter

- The answer to the question posed in the chapter title: to put it more fully, ‘Why do I always get irritated and angry at things that don’t bother other people, and how do I sort it out?’
- The most common errors made in the appraisals and judgements people make of triggering situations.
- How to analyze some of the examples we have covered so far in terms of those common errors, so you get good at identifying such errors.
- How to make better appraisals and judgements and avoid the errors described.
- How to change your own behavior – permanently.

Why do I always get irritated and angry at things that don’t bother other people?

We covered this earlier on, but just by way of revision:

- A potential trigger for anger occurs: e.g. you find your 12-year-old daughter in the bath washing her hair instead of tidying her room, having been asked to do so repeatedly.
- You make an appraisal/judgement of that situation which is likely to produce anger: e.g. ‘She’s deliberately being defiant, she’s just trying to wind me up.’ (It’s worth noting at this stage that there is a possible alternative appraisal along the lines of ‘Well, she’s not tidying her room but at least she’s keeping herself clean and tidy.’)
- Assuming you made the anger-inducing appraisal, anger ensues.
- Your inhibitions may be strong enough to prevent the anger becoming apparent to anybody else.
- Or possibly your inhibitions are not that strong, so the potential recipient gets a piece of your mind: e.g. the daughter gets shouted at.

In Part One we summarized this process with the model shown again here in Figure 10.1.

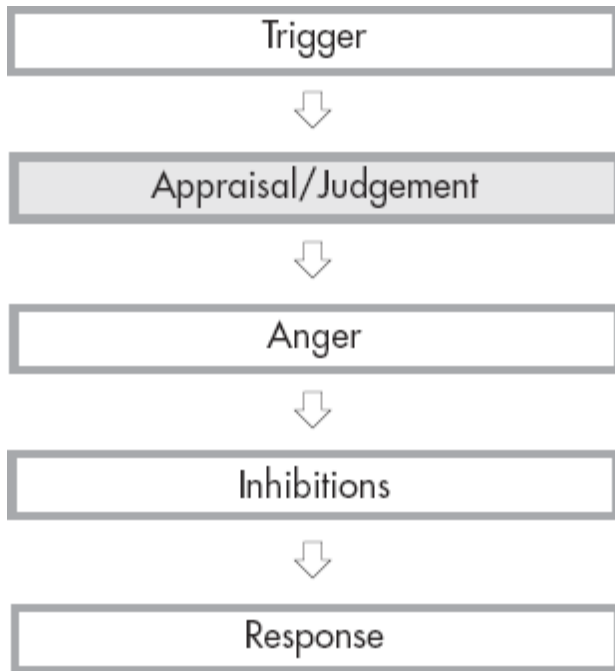


Figure 10.1 A model for analyzing irritability and anger

Appraising and judging in triggering situations: The most common errors

Happily, psychologists have completed a great deal of research into the kind of unhelpful appraisals that people make. And it turns out that such appraisals are not simply random: there are certain specific types of ‘errors’ that people tend to make. I’ve put the word ‘errors’ in quotes because while the appraisals may not necessarily be *wrong*, they are generally *unhelpful* to you. Read on and you will see what I mean.

A number of labels are given to the different categories of unhelpful appraisals that people make. Below are the ones that I think are the most important.

Selective perception

This means just what it sounds like: in other words, a person sees part of the story but not the whole story. For example, in the case of Anne’s 12-year-old daughter sitting in the bath washing her hair, she was indeed ‘not tidying her room’ – but that was only part of the story. She was also keeping herself clean and tidy. In fact, as it turns out, this was particularly relevant because she was appearing in a school play the next morning, so it was relevant that she was ‘well turned out’. However, to her mother’s perception she was simply ‘not tidying her room’.

Mind-reading

Again, this is exactly what it says. In our example it is manifested by Anne saying: 'She does it deliberately to wind me up.' How does she know her daughter does it to wind her up? The only possible answer can be by mind-reading. The point is that mind-reading is impossible, as far as we know. So Anne has no idea whether her daughter is really trying to wind her up deliberately or not. Therefore it is entirely unhelpful to jump to that conclusion. She might just as well jump to the opposite conclusion, that her daughter is *not* trying to wind her up deliberately. This is a very common way of thinking: many people assume that the person who irritates them does it deliberately.

Awfulizing

A clumsy word, but a good one for what it means. It refers to that phenomenon whereby, when we don't get what we want, we will see the situation as 'awful'. So, to take this example again, whereas some mothers, having failed to get their daughters to tidy their rooms, would tell somebody else: 'I wish I could get my daughter to tidy her room. Do you know I spent all day nagging her to do it yesterday and still she didn't do it,' other mothers will see it as 'awful' and 'the end of the world'. It is one example of 'thinking in extremes' or 'black and white thinking': seeing things as *either* wonderful *or* terrible, *either* perfect *or* awful, etc. It is good practice to develop the habit of thinking and talking in shades of grey, where, for example, events may be 'not as I want' but are not necessarily 'awful'.

Use of emotive language

Which is the particularly emotive word that Anne used about her 12-year-old daughter? The one that I would pick out is 'defiant'. She viewed her daughter as being deliberately defiant. This is a very strong word designed to make adversaries of mother and daughter. If one person defies another, then surely it is the first person's duty to overcome that defiance. This is likely to be a very unhelpful way of phrasing things.

Incidentally, although I am writing this as though we are talking out loud to somebody else, when we make our appraisals and judgements this is not normally the case; normally, the 'conversation' is with ourselves. That being the case, the language can be even more emotive. We can think nothing of referring to other people, even our own family, as 'bastards' and worse.

Overgeneralization

This is where we notice a particular observation which is true (e.g. that the girl in question has not tidied her room) and then make a sweeping generalization from that fact (e.g. 'She's bone idle' or 'She never does anything I ask her to'). It is usually far better to stick to the accurate statement, i.e. 'It is very difficult to get her to tidy her room.' This of course puts her on a par with just about every other youngster, and it also clarifies what the problem is (trying to get her to tidy her room). Overgeneralizations are very common and usually very destructive.

EXERCISE

These five types of errors in appraisal and judgement are very important. Therefore I would like you to stop

reading for a moment and just look back over the five headings; then see if you can think of an example for each of the five where you have actually thought or reacted in the way described. In other words:

- an example of you showing selective perception (noticing only one aspect of a situation);
- an example of where you were 'mind-reading' (assuming you knew someone's intention when you could not possibly have done so);
- an example of 'awfulizing' (where you portrayed to yourself that what has happened is absolutely 'awful' rather than just 'not what you would have wished');
- an example of you using emotive language to yourself (describing an event in a way which is almost bound to get you 'fired up');
- an example of you 'overgeneralizing' (noticing something that is true, but going way over the top with a generalization from it).

However, take care not to blame yourself for any of these; all of them are very common indeed, but do tend to be rather unhelpful for you.

What errors of appraisal/judgement are being made here?

Below are a number of examples of triggers, along with the appraisal/judgement that was made by the recipient. After each example is a list of the five errors in appraisal/judgement. Your task is to underline all the errors which apply to each example (sadly, one appraisal can exhibit several of the errors). You may wish to circle the error which you think is the main one in each case.

The first three examples have been done for you:

1 *Trigger*: Gerry has noisy neighbours playing music loudly next door. This happens every week or so and normally lasts for an hour or two.

Gerry's appraisal: 'They do that deliberately to annoy me – they don't give a damn about what I think.'

Error(s): selective perception / mind-reading / awfulizing / emotive language / overgeneralizing.

2 *Trigger*: Colin's neighbours' kids are playing football in the street outside. This happens every few days and normally their game lasts for about forty-five minutes.

Colin's appraisal: 'They're a bloody nuisance, they've got no respect for anybody, it makes it not worth living here.'

Error(s): selective perception / mind-reading / awfulizing / emotive language / overgeneralizing.

3 *Trigger*: A fifth man comes into the bar where Steve is sitting with Ben and Chris and leaves a door open (four others having done so previously).

Steve's appraisal: 'They just don't give a damn about anybody.'

Error(s): selective perception / mind-reading / awfulizing / emotive language / overgeneralizing.

4 *Trigger*: Pam's husband eats food noisily and talks to her at the same time.

Pam's appraisal: 'I just can't stand the way he eats, it just shows how he's not my type of person.'

Error(s): selective perception / mind-reading / awfulizing / emotive language / overgeneralizing.

5 *Trigger*: Sue's teenage son Ian drops a china mug on the floor and it breaks. (Note:

we know that Ian takes great care over his homework.)

Sue's appraisal: 'He doesn't take any care about anything, he just doesn't give a damn.'

Error(s): selective perception / mind-reading / awfulizing/ emotive language / overgeneralizing.

6 *Trigger:* Judy has to wait a long time in the outpatient department with her five-year-old daughter. Having witnessed the doctor and nurse working carefully with a number of patients, she then sees them having a tea-break after an hour and a half, relaxing and chatting to each other.

Judy's appraisal: 'They don't care about any of us, all they are interested in doing is relaxing and flirting with each other.'

Error(s): selective perception / mind-reading / awfulizing / emotive language / overgeneralizing.

7 *Trigger:* Out at a party, Nigel's wife contradicts him several times in front of others.

Nigel's appraisal: 'She's doing it deliberately to show me up and make me look small – I just can't stand her any longer.'

Error(s): selective perception / mind-reading / awfulizing/ emotive language / overgeneralizing.

8 *Trigger:* Alan's otherwise fair boss asks him to do another task towards the end of the day which will take him over his normal finishing time.

Alan's appraisal: 'He always treats me unfairly, he's just a lousy bastard.'

Error(s): selective perception / mind-reading / awfulizing / emotive language / overgeneralizing.

9 *Trigger:* Danny has told his long-time partner Vicky something he took to be in confidence. Vicky, however, has told several other people about this.

Danny's appraisal: 'That's totally out of order – she has got absolutely no sense of what's right and wrong.'

Error(s): selective perception / mind-reading / awfulizing/ emotive language / overgeneralizing.

10 *Trigger:* Graham and Fiona have been married several years. Fiona has never had an extra-marital relationship and is generally a very good partner for Graham. However, she does sometimes flirt with other men.

Graham's appraisal: 'She's got no loyalty whatsoever; if I turned my back on her she'd be off like a shot.'

Error(s): selective perception / mind-reading / awfulizing / emotive language / overgeneralizing.

11 *Trigger:* Brian, standing at the bar, has his elbow jogged and beer spills down his front.

Brian's appraisal: 'He did that deliberately.'

Error(s): selective perception / mind-reading / awfulizing/ emotive language / overgeneralizing.

12 *Trigger*: Paul's twelve-year-old son says that he has done his homework in order to get to watch television sooner.

Paul's appraisal: 'The kid's completely useless, I don't know what's going to happen if he carries on like this, he's going to do no good.'

Error(s): selective perception / mind-reading / awfulizing/ emotive language / overgeneralizing.

13 *Trigger*: David sees a teenager stealing the stereo from the car.

David's appraisal: 'The kid was an animal, just thinks he can take what he wants, doesn't give a damn about anybody, the arrogant sod.'

Error(s): selective perception / mind-reading / awfulizing/ emotive language / overgeneralizing.

14 *Trigger*: A bouncer outside a club speaks in a mildly irritated tone to a Tina, a twenty-year-old customer.

Tina's appraisal: 'Who does he think he is, these bloody bouncers think they own the place.'

Error(s): selective perception / mind-reading / awfulizing/ emotive language / overgeneralizing.

15 *Trigger*: A car overtakes Chris's car and pulls in sharply in front of it in a line of traffic to avoid an oncoming car.

Chris's appraisal: 'Arrogant bastard, he only does that because he's got a Porsche, he's just trying to make everyone else look small.'

Error(s): selective perception / mind-reading / awfulizing / emotive language / overgeneralizing.

The answers I would give are as follows:

4 *Trigger*: Pam's husband eats food noisily and talks to her at the same time.

Pam's appraisal: 'I just can't stand the way he eats, it just shows how he's not my type of person.'

Error(s): selective perception / mind-reading / awfulizing / emotive language /

overgeneralizing.

5 *Trigger*: Sue's teenage son Ian drops a china mug on the floor and it breaks. (Note: we know that Ian takes great care over his homework.)

Sue's appraisal: 'He doesn't take any care about anything, he just doesn't give a damn.'

Error(s): selective perception / mind-reading / awfulizing / emotive language /

overgeneralizing.

6 *Trigger*: Judy has to wait a long time in the outpatient department with her five-year-old daughter. Having witnessed the doctor and nurse working carefully with a number of patients, she then sees them having a tea-break after an hour and a half, relaxing and chatting to each other.

Judy's appraisal: 'They don't care about any of us, all they are interested in doing

is relaxing and flirting with each other.'

Error(s): selective perception / mind-reading / awfulizing / emotive language / overgeneralizing.

7 *Trigger:* Out at a party, Nigel's wife contradicts him several times in front of others.

Nigel's appraisal: 'She's doing it deliberately to show me up and make me look small – I just can't stand her any longer.'

Error(s): selective perception / mind-reading / awfulizing / emotive language / overgeneralizing.

8 *Trigger:* Alan's otherwise fair boss asks him to do another task towards the end of the day which will take him over his normal finishing time.

Alan's appraisal: 'He always treats me unfairly, he's just a lousy bastard.'

Error(s): selective perception / mind-reading / awfulizing / emotive language / overgeneralizing.

9 *Trigger:* Danny has told his long-time partner Vicky something he took to be in confidence. Vicky, however, has told several other people about this.

Danny's appraisal: 'That's totally out of order – she has got absolutely no sense of what's right and wrong.'

Error(s): selective perception / mind-reading / awfulizing / emotive language / overgeneralizing.

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Graham's appraisal: 'She's got no loyalty whatsoever; if I turned my back on her she'd be off like a shot.'

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Brian's appraisal: 'He did that deliberately.'

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Paul's appraisal: 'The kid's completely useless, I don't know what's going to happen if he carries on like this, he's going to do no good.'

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David's appraisal: 'The kid was an animal, just thinks he can take what he wants,

doesn't give a damn about anybody, the arrogant sod.'

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Tina's appraisal: 'Who does he think he is, these bloody bouncers think they own the place.'

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15 *Trigger:* A car overtakes Chris's car and pulls in sharply in front of it in a line of traffic to avoid an oncoming car.

Chris's appraisal: 'Arrogant bastard, he only does that because he's got a Porsche, he's just trying to make everyone else look small.'

Error(s): selective perception / mind-reading / awfulizing / emotive language / overgeneralizing.

SUMMARY OF THE MAIN APPRAISAL/JUDGEMENT ERRORS

- Selective perception: Where one or more important aspects of the situation are unnoticed.
- Mind-reading: Where a person believes s/he knows what is in another person's mind, especially their intention.
- Awfulizing: Where some unwanted event is viewed as awful, tragic, terrible, disastrous, etc., rather than simply unwelcome.
- Emotive language: Using strong language to oneself, almost automatically producing an angry reaction.
- Overgeneralization: Making a sweeping generalization from one true observation.

Applying this to your own situation

Now you've shown you can analyze other examples, you need some examples from your own life to work on. To get these, we need a slightly more sophisticated diary, as shown opposite.

Diary 2

Fill this in as soon as possible after each time you get irritable or angry.

Trigger: Describe here what a video camera would have seen or heard. Include the day and date, but do not put what you thought or how you reacted.

Appraisal/Judgement: Write here the thoughts that went through your mind, as clearly as you can remember them.

Anger: Leave this blank for the time being.

Inhibitions: Leave this blank for the time being.

Response: Write here what a video camera would have seen you do and heard you say, as clearly as you can.

More helpful appraisal/judgement: How else might you have appraised the situation? To determine this, you might like to consider the following: What errors are you making (selective perception, mind-reading, awfulizing, emotive language, over-generalization)?

If you had an all-knowing, all-wise friend, how would s/he have seen the situation?

Is a reframing of the situation possible? (A glass that is half empty is also half full.)

What would your cost-benefit analysis be of seeing the situation the way you did?

Methods of making your appraisals/judgements more helpful

There are four major ways of doing this.

Identify and remove 'errors' of judgement

This starts with analyzing your appraisal/judgement. So, for example, Anne, who saw her daughter 'not tidying her room', might realize that this was selective perception. In other words, while it was true the girl was not tidying her room, she was washing her hair and thereby making herself clean and tidy for the next morning's school play. This positive aspect of the girl's behavior was something that had completely eluded Anne. She had truly only perceived the fact that her daughter was not tidying her room. Once this 'error' had been spotted, the situation almost automatically rectified itself.

In the same way, Anne might also see that she was 'mind-reading', another 'error'. In this instance she was saying to herself that her daughter was 'deliberately winding her up'. Clearly this is mind-reading; how could the mother possibly know that the daughter had that intention? Once this has been spotted as an 'error', Anne believed it less firmly.

She also recognized that she was 'awfulizing'. In other words, she was making the fact that her daughter had not tidied her room into the 'biggest thing in the world' – in her own words, 'getting it out of proportion'.

She was also using emotive language, describing her daughter as 'defiant'. This is a strong word which produces strong emotional reactions. What is more, it is also mind-reading: it implies that Anne can tell that the daughter has a particular motive in mind. The 'error' of using emotive language is easily corrected – you simply refrain from using it. You simply delete from your mind the phrase where the word 'defiant' was used.

And the final error is over-generalization: in this instance, saying that the daughter

was ‘bone idle’. This was not actually true: there are all sorts of other things that the daughter did perfectly well (for example, keeping herself clean and tidy, joining in the school play, etc.). Again, in this instance once the ‘error’ has been spotted, the situation almost automatically corrects itself.

It is perhaps worth making the point that there are rather few examples that illustrate all five errors simultaneously, and that is why this episode of Anne and her daughter is something of a ‘collectors’ item’!

The ‘friend technique’

This is where you say to yourself: If I had an all-knowing, all-wise friend, someone who had only my interests at heart, how would s/he appraise this situation so that it worked out best for me?

In this instance the friend might say something like ‘Come on, Anne, just leave the girl alone. She’s a good girl, and at least she’s keeping herself clean and tidy which is a step ahead of a lot of kids. Anyway, how many kids do you know who tidy their rooms when their mums ask them to?’

This can be a powerful technique if you practice it regularly and if you can build up a good image of this all-knowing, all-wise friend. It does not have to be anybody real – perhaps it’s helpful if it isn’t – just so long as it is a very wise person who has your interests at heart, someone who is always on your side.

Incidentally, some people prefer to do it the other way around: in other words, ask themselves: ‘What would you say to a friend in this situation, a really good friend to whom you wanted to offer constructive support?’

Reframing the trigger

Most ‘bad news’ can also be reframed as ‘good news’. The most famous example is the glass of water that is half empty (bad news). It is of course also half full (good news).

So how might you reframe the situation where, in spite of being nagged all day long, your 12-year-old daughter is sitting in the bath washing her hair rather than tidying her room? There are in fact several options here. One is to simply focus on the good aspect, the ‘half full’ aspect: namely, in this case, the fact that she is keeping herself clean and tidy and preparing for the school play. Another is that clearly the daughter feels relaxed enough with her mother, and ‘un-frightened’ enough of her, not to feel that she has to do exactly what she’s told. This ‘quality of relationship’ aspect is normally viewed as good news and would not usually produce anger. A third possible reframe is that in fact the daughter is displaying assertiveness and perseverance by not simply doing what she is told. Both these characteristics are rightly viewed as good qualities to encourage in youngsters.

Some situations are much more difficult to reframe. Take the example of Steve, where every other person who comes into the bar leaves the door open: how might that be reframed? It is very difficult to see anything intrinsically good about people leaving the door open just near where you are sitting. On the other hand, if you look at the situation in a much wider perspective, maybe it is just possible. The overall situation is, after all, that there you are sitting with two friends having a good drink and a talk and occasionally somebody leaves the door open. Supposing you were to have a conversation with some chap who had just lost all he owned in an earthquake

in Turkey, or a man who had lost his loved ones in the floods in Bangladesh, or a woman who had lost everything and everybody in a natural catastrophe in South America. Suppose you were to suggest to this individual that there is a chap sitting in a bar drinking happily with his two friends who views it as a disaster when several people leave the door open by him. What sort of reaction would you be likely to get?

That, strictly speaking, is reframing: it puts the event in a different context. And it might just sway the person concerned; you might just be able to use it. Curiously, though, my experience is that it *doesn't* often do the trick. Only when there is real personal relevance (as in the first example of seeing the 12-year-old daughter as 'a good kid looking after herself and getting ready for the play at school next day') do people really latch onto it. Nevertheless, I mentioned the second example of reframing because it is one that works well for me personally; so, who knows, it might work for you too.

Cost–benefit analysis

Doing a cost–benefit analysis of your appraisal/judgement is, happily, not half so difficult as it sounds. It's really just a matter of looking at the pros and cons.

For consistency's sake it would probably be a good idea to stick to just one example for the most part while we go through these options, namely our mother Anne with her 12-year-old daughter. But I'm getting a bit fed up with that example, so let's look instead at Paul, the father with the son, also aged 12, who hadn't done his homework properly but said he had so he could watch the television. When Paul had a look at the homework and saw how little had been done his appraisal was something like this: 'The boy's a liar, he's tried to pull the wool over my eyes, where's he going to get to if he carries on like this? He'll come to no good in life, all the other kids at school will do better than him . . .'

Clearly this is a piece of selective perception in that there are probably other aspects to the boy that we haven't been told about; his life cannot begin and end with that one piece of undone homework. Nevertheless, the father's appraisal/judgement may indeed turn out to be correct. The only thing is, we would have to wait for a number of years before we would find out one way or the other. And even then it might only be correct because it was a self-fulfilling prophecy.

In the meantime, what are the pros and cons of making an appraisal/judgement like that? Let's do the cons (against) first:

- it agitates the father;
- it makes the boy feel inadequate;
- it worsens the relationship between father and son;
- it labels school work as a thoroughly punishing business . . .'

. . . and there are probably more cons that you can think of. On the 'pro' side there's – well, precious little that I can imagine. Possibly it might motivate the son to do more homework next time; but then again, it might motivate him to be a bit more devious next time so he can get away with it.

What about an appraisal/judgement along the lines of: 'The kid has clearly got no idea what he's doing, I'd better see if I can help him out or see if he knows somebody else who can if I can't'? Clearly the cost–benefit analysis in this case swings right round the other way. The benefits of such an appraisal are:

- an improvement in the father–son relationship;
- better school work;
- probably more openness about how things are going . . .

. . . and so on. The costs are probably significant too: predominantly, a drain on the father’s time. On balance, however, the second appraisal/judgement produces a much better cost–benefit analysis for all concerned than the first one.

Now, if you’re like anybody else, you may say that you can’t decide how to think on the basis of a cost–benefit analysis; you think according to what is ‘true’. Well, maybe; but I would tend to disagree, because we’ve seen that it is very difficult to see what is ‘true’ in this instance – and indeed in many others. And moreover, if you look at how people do think, even down to something as tangible as which political party to vote for, it very often is to do with what would benefit them the most and cost them the least.

THE MAIN METHODS OF PRODUCING MORE HELPFUL APPRAISALS/JUDGEMENTS

- Identify the error (selective perception, mind-reading, awfulizing, emotive language or overgeneralisation) and correct it.
- The ‘friend technique’. How would an all-knowing, all-wise friend advise you to view the situation?
- Reframe the situation. Search for the good aspects of it, or, failing that, view it from a completely different perspective.
- Conduct a cost–benefit analysis. That is, examine the costs and benefits of appraising the situation the way you are, and then look for a more cost-effective way.

EXERCISE

Graham’s wife, Fiona, occasionally indulges in ‘harmless flirting’ with other men – merely in high spirits, with no intention of getting involved in an extra-marital relationship. Graham, however, gets very jealous and produces an appraisal/judgement along the lines of: ‘She’s showing me up, people will think I’m not making her happy, I’m losing face, she’s out of order.’

- 1 What alternative appraisal would an all-knowing, all-wise friend make?
- 2 How might Graham reframe this behavior?
- 3 What would a cost–benefit analysis of Graham’s appraisal look like? Can you suggest a better appraisal?

Below are the kind of answers that I produced, but I would strongly suggest that you produce your own before you have a look at these:

- 1 A reassuring friend might say: ‘Come on, Graham, you know perfectly well that Fiona is as faithful as the day is long, she’d never let you down, she thinks you’re the best thing since sliced bread. She just likes to have lots of fun but everybody knows what she thinks of you.’
- 2 Graham might reframe the situation as: ‘It’s good that Fiona feels secure enough in our relationship that she can have a great time and know that I won’t take it amiss and neither would anybody else.’
- 3 A cost–benefit analysis of Graham’s original appraisal/judgement is that the ‘costs’ are rather heavy: his appraisal will make him anxious, jealous and possibly angry. It will put a strain on the relationship, it will limit Fiona’s activities, make her feel that Graham doesn’t trust her and generally put a damper on all their activities. The only benefit of such an appraisal is that at least it lets Fiona know that Graham cares about her – but she probably knows that anyway. Yes, a better appraisal would be along the lines of (1) or (2) above.

Let’s look at another example . . .

EXERCISE

Vicky, while being interviewed on a radio programme, mentioned that her husband Danny likes to wear her thongs. Danny, who is also in the public eye, took a very dim view of this, making an appraisal/judgement along the lines of: ‘Has she got no sense? Doesn’t she realize that some things are just between us? Is she

deliberately trying to make my life as difficult as possible? She's just completely stupid! Needless to say, this made Danny very angry with Vicky.

- 1 What error of thinking was Danny making?
- 2 What alternative appraisal would an all-knowing, all-wise friend make?
- 3 How might Danny reframe what Vicky did?
- 4 What would a cost-benefit analysis of Danny's appraisal look like? Can you suggest a better appraisal?

Again, there is a list of answers that I would make below, but I would suggest that you produce your own before you have a look at these.

- 1 Danny is making a lot of thinking errors. Particularly, he is using emotive language ('she's completely stupid') and over-generalizing (just because she has said one thing – or even several things – which would be best left unsaid, it does not mean that she is completely stupid; probably there are lots of other things which would suggest she is far from stupid). One might also say that Danny is mind-reading (assuming that Vicky is trying to make his life as difficult as possible). Likewise, you could say that he is indulging in selective perception (because Vicky probably does other things which make his life good) and you might even say he is awfulizing (is it really so bad that people know that he and his wife have an intimate side to their relationship?).
- 2 An all-knowing, all-wise friend might say 'Oh, look, Danny, there's no need to make quite such a big deal out of it. You know that Vicky thinks the world of you and wouldn't deliberately do things to make things difficult for you. So what if other people rib you a bit? It only shows that they're jealous. Just put it to one side.'
- 3 How might Danny reframe what Vicky said and did? He might say that it is good that Vicky feels so relaxed and secure in their relationship that she doesn't have to watch every word she says, even when she's being interviewed on nationwide radio. He might even say that it adds to his street-cred that he has a pretty adventurous private life as well as the public one that most people see. He could even relish the fact that other people are made jealous by what she said.
- 4 A cost-benefit analysis would look something like this. The costs of the appraisal that Danny is making originally are heavy: it puts a strain on his relationship with Vicky, it makes him feel stressed out in general, it makes him angry with Vicky. The benefits are few: possibly it might make Vicky a bit more cautious about what she says in future, but does Danny really want her to be nervous about everything she says? A better appraisal would be something like the 'best friend' said in (2) above. That would have lots of benefits for Danny and no costs.

And another one ...

EXERCISE

When thirteen-year-old Ian accidentally dropped a mug on the kitchen floor and it broke, his mother Sue 'completely lost it'. Her appraisal was that 'The kid is spoiled to death, he just doesn't realize that things cost money, he just doesn't give a damn. He thinks I'll clear up after him, buy everything that's necessary and just act as his slave. Well, it's about time he learned a lesson.' Again,

- 1 What errors in thinking is Sue making?
- 2 What alternative appraisal would an all-knowing, all-wise friend suggest?
- 3 How might Sue reframe what Ian did?
- 4 What would a cost-benefit analysis of Sue's appraisal look like? Can you suggest a better appraisal?

And again you are probably best to work the answers out yourself before going on to read the ones below.

- 1 Sue is using emotive language ('he doesn't give a damn, he thinks I'll act like his slave, it's about time he learned a lesson'), she is mind-reading (how does she know he doesn't give a damn?) and she is probably overgeneralizing (just because he drops the occasional mug it doesn't mean he doesn't care about things or that he sees his mother as a slave).
- 2 An all-knowing, all-wise friend might say 'Listen, Sue, how much does a mug cost? And is it really that difficult to sweep up a broken mug? In any case, you could get him to do that, and that would probably be the best way of him 'learning a lesson', as you put it. Now, just calm yourself down and get him to clear up the bits.'
- 3 Possibly Sue might reframe the incident as another small part of Ian's development, in that he learns that when you make a mistake, even a small one, like breaking a mug, you have to rectify it – in this case, sweep up the pieces. Or she could look at it from a completely different perspective: she could take the view of one of the millions of people in the world whose lives are seriously at risk on a daily basis and then ask herself how one such person would perceive the breaking of a mug that was easily replaced.
- 4 A cost-benefit analysis of Sue's appraisal would be that the costs to her are heavy: she is stressed-out, agitated, angry with Ian and wearing down the relationship between them. The benefits of such an

appraisal are slim: possibly Ian might be somewhat more careful next time, but equally possible he may be so nervous next time he is in the kitchen with his mum that he is *more* likely to drop something; or perhaps he might not even risk making himself a drink when she's about, so she would see less of him around the house. Again, a better appraisal would be that of the best friend or even possible that [in (3) above] of a person whose life is constantly at risk on a daily basis, i.e. 'a broken mug is nothing to worry about.'

So how do you change really, permanently?

The RCR technique

RCR stands for *Review, Cement, Record*. And each of these is very important.

Reviewing means you examine events that happen to you (and especially events when you have felt angry and irritable) in exactly the same way as we have done in the three exercises we have just looked at. In other words, you actually write down what happened to you in exactly the same way as in each of these exercises. The description can be quite brief; it need only take up a few lines. Importantly, though, it does contain both the event and your appraisal of it – just like the three examples in the exercises. And again, just as in the exercises, you take yourself through the four stages of analysis. Use Diary 2 if you want.

The purpose of this is for you to form a judgement as to how you should best view the event. Now, you might say that you can't *decide* how to view an event – an event happens and your appraisal/judgement appears in a flash and is therefore the true one. A lot of us feel this; but I'm afraid it is the thinking of a five-year-old: 'Because I see it this way it *is* this way.' Not at all. Events happen, and there are as many different ways of seeing them as there are people in the world. What you have to do is to come to a judgement as to your best way of seeing it, the way that is in your best interests.

This can be tricky, because by now you will certainly be well into the habit of seeing things in particular ways, and changing those ways is quite a task. Rather like finding your way through a jungle, it is always easier to take the already existing paths. However, it is unfortunate for you if those paths happen to be 'the awfulizing path', 'the emotive language path', 'the mind-reading path' and so on.

There is some good news, though: as far as the brain is concerned it doesn't really matter much whether you do things in reality or in imagination. What this means is that simply reviewing things in the way I have just described, taking yourself through the four stages of analysis, and simply *imagining* thinking in the most cost-effective way is almost as good as actually doing it at the time of the event – in terms of changing your patterns of thinking. Nevertheless, you do have to do it lots of times. Effectively, you are beating a new path through the jungle of the brain; and you have to keep treading down that path to make it a viable route. So keep reviewing, keep taking yourself through the four stages, and keep settling on the most cost-effective appraisal.

(For those of you who watch cricket, you will sometimes see a batsman rehearsing the stroke *he should have played*. On the face of it this seems a pretty daft thing to do, as the ball has just gone whistling past him and he played a rather poorer stroke than the one he is now rehearsing. Not so, however: that rehearsal he is now doing is in fact treading down a better path through the jungle of the brain. The next time a cricket ball comes hurtling towards him in similar fashion there is a better chance that he will take that new improved path rather than the previous faulty one. For those of

you who are not interested in cricket, you must wonder what on earth I am going on about. Don't worry. Think jungle.)

Cementing is equally important. Just as it's impossible to distinguish between the relative importance of brakes and steering on a car, so with reviewing and cementing. They are both essential.

What you do with cementing is to act out the appraisal you settled on during the review stage. In other words, thinking something is not enough; you actually have to *behave* that way. I call it cementing because it figuratively cements, fixes, the thoughts you have produced. Thoughts and behavior make a very strong combination – indeed, this is the key combination that underlies a cognitive behavioral approach to solving problems.

So, in the examples given in the exercises above, Graham must 'act out' being pleased that Fiona feels secure enough in the relationship that she can have a great time by flirting with other men. This is more than simply pretending, because by now Graham really has reframed the situation and has got his new cost-effective appraisal; so it is a question of 'acting out what he thinks' rather than pretending. In other words, he would joke with Fiona about it all afterwards, might tease her about it while it is going on, and so on.

Likewise, Danny will genuinely act out his new more cost-effective appraisal to the slip-ups that Vicky makes. So he can tease her about how her mouth runs away with her, the new perception that other people have of him, and so forth.

Sue, too, will cement her new appraisal by *calmly* asking Ian to sweep up the remnants of the mug, in due course *calmly* buy a replacement mug or two, and so on.

Importantly, this need not just be retrospective. Graham can be sure that he reacts this way to *future* flirting episodes from Fiona; Danny can be sure he reacts this way to *future* misjudged comments from Vicky; and Sue should ensure that she reacts this way to *future* 'careless acts' from Ian.

Recording is the part where you reap the pay-off: now you can simply enjoy feeling extra smug. All you do is write down a brief account of events as they happen; so, the next time Fiona does some of her flirting, Graham writes down a brief account of it, what his (new, improved) appraisal was, and how he reacted during and after the event. And this will make good reading for him because it will be such an improvement on his previous responses. Again, he could use Diary 2 if he wanted.

Likewise, Danny will simply make a brief note about Vicky's latest gaffe, what his new, improved appraisal was, and how he reacted during it and afterwards. And Sue will do just the same, keeping an account of the things that Ian gets up to, her new appraisals and her new reactions.

So the recording stage is clearly the most fun and enables you to see that your hard work is paying off in a good way: not just that those around you are not having to suffer your irritability and anger, but that you are genuinely seeing things in a different light, one which is more beneficial for you too.

SUMMARY

- The reason why you get irritated and angry at things that don't seem to bother other people is that you make different appraisals and judgements about those events.
- The most common errors made in appraising and judging situations are selective perception, mind-reading, awfulizing, using emotive language and overgeneralization.
- It is straightforward – with lots of practice – to analyze examples and see the errors that are being made.

- It is possible to make appraisals and judgements that are better for all concerned, making both you and other people feel better about the situation. The main ways of doing this are: (a) identify the error and correct it, (b) the 'friend technique' (how will an all-knowing, all-wise friend advise you to view the situation?), (c) reframe the situation by searching for good aspects of it or viewing it from a completely different perspective, and (d) conduct a cost-benefit analysis, examining the costs and benefits of appraising the situation the way you are doing and then looking for a more cost effective way.
- You can bring about a permanent change in your own behavior by the RCR technique. This means *reviewing* events as they crop up and conducting the four-stage analysis to produce more helpful appraisals and judgements, *cementing* this new, more cost-effective appraisal by behaving in a way that matches it, then *recording* the results to further consolidate the gains and generally make you feel good about your progress.

PROJECT

The best project you can do to apply this chapter to your own situation and thereby change your own behavior is as follows:

- Keep a record of events that trigger your anger and, most importantly, what your appraisal of those events is. Use Diary 2 if you want.
- Analyze your appraisals and produce better, more helpful, more cost-effective ones. A brief account of how to do this is contained in the fourth point of the summary above.
- Cement your new appraisals by acting in line with them. This is a strong technique where your thoughts and behavior support each other.
- It is a good idea also to record in writing what you have just done (the trigger, your new appraisal, how you cemented that new appraisal); this cements things even further.

Why do I get angry? 2: Beliefs

We covered a great deal of ground in the previous chapter, and if you have acted on it you will already have made a terrific impact on your own irritability and anger. Nevertheless, there is a question that might have occurred to you, and it is a question that can appear in several forms, as follows:

- Why is it always *me* who makes these unhelpful appraisals and judgements, rather than my friend John, Kate or whoever?
- Why was it Steve who got angry about the guy who came into the bar and left the door open, rather than Ben or Chris?
- Why was it that Sue made the unhelpful appraisal/ judgement when her teenage son dropped her mug on the floor, whereas other mothers don't make such unhelpful appraisals?
- Why did Anne make such an unhelpful appraisal of her twelve-year-old who was washing her hair in the bath (not tidying her room) while some other mothers wouldn't?
- Why is it that when Chris is 'cut off' by another motorist, he makes an appraisal that gets him really angry, whereas other motorists will just shrug it off?

Of course, these are all simply different forms of the same question: namely, why are some people 'set up' to make unhelpful appraisals whereas other people seem to be 'set up' to make helpful appraisals?

Again, we talked about this in Part One; in this chapter we will look at how to remedy the situation. If you are someone who is prone to make unhelpful appraisals, appraisals which lead you to be irritable and angry quite often, then this is your chance to reprogramme yourself. And, perhaps surprisingly, it's not too difficult; in fact, it can be quite a lot of fun.

Let's go back to our model. We can see from the diagram that the way we appraise things is influenced partly by our beliefs. We've shaded that box in because that's the box we're going to focus on in this chapter. We are going to look at how those beliefs influence the way we appraise things and how we can alter those beliefs; because if we can do that, then we will automatically alter our appraisals without any further effort. We will, effectively, be a significantly different person, someone who is fundamentally less prone to be irritable and angry.

You can see from the diagram on page 144 that by changing the beliefs we will change the whole course of events.

Incidentally, you might be thinking that it's not so much that you are *always* prone to make unhelpful appraisals, it's just that *sometimes* you are. Particularly when you just 'feel irritable'. In that case, Chapter 15 on 'mood' is going to be particularly relevant to you. Even so, if you are wondering whether it's worth your while reading

this chapter (and all the others between here and Chapter 15) then I would suggest that the most likely answer is: ‘Yes, it is.’ This one in particular is just such a good chapter! It looks at things which are absolutely fundamental and yet relatively easy to change. So, potentially there is a big pay-off for little effort, and pleasurable effort at that.

What sort of beliefs are we talking about?

What we are dealing with here are beliefs about yourself, about other people, about the nature of the world, about how things should be, about how life is to be lived, and so on. We are *not* concerned with beliefs on matters of fact (as in, I believe it is about 3,500 miles from London to New York, or I believe the capital of Australia is Canberra).

A lot has been written about the beliefs that people hold and how helpful or otherwise they are. People have made lists of unhelpful beliefs – beliefs that make you anxious, beliefs that make you depressed, and so forth. In my experience, having read lots of lists and seen lots of irritable and angry people, my own list of unhelpful beliefs is as follows:

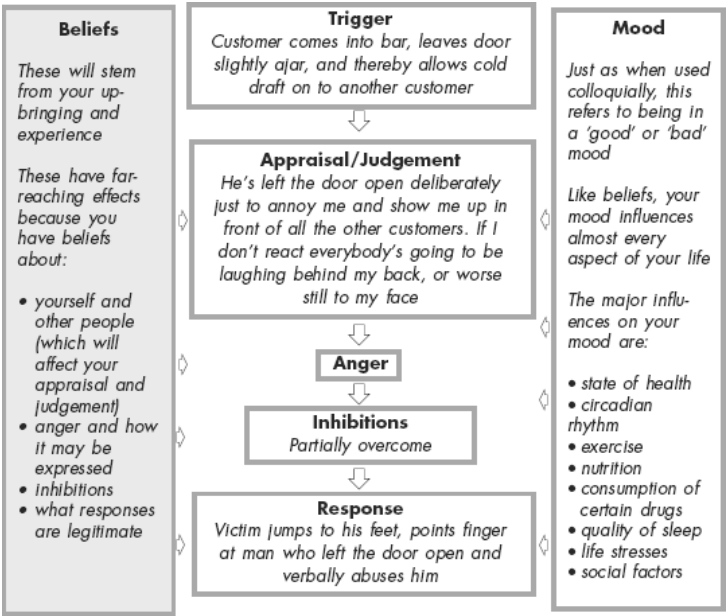


Figure 11.1 A model for analyzing irritability and anger

- Things should be just exactly how I want them to be. It is awful if they are not.
- People don't take any notice of you unless you show that you are irritated or angry. It is the only way of making your point.
- Other people are basically selfish, self-centred and unhelpful. If you want them to help you, you have to *make* them.
- Other people are basically hostile. You have to be on the alert, otherwise they will take any

opportunity to put you down.

- If people do wrong they must be punished. You can't let people get away with things.

We could add to this another list of unhelpful beliefs which are a bit more specific, referring to particular situations or particular people:

- It's okay to get angry with/hit policemen, bouncers, etc.
- A parent/foreman/manager/supervisor is *meant* to be snappy, irritable and harsh. (Where you are a father/mother/foreman/manager/supervisor).
- My father/mother/partner/son/daughter is a complete pain in the neck, it irritates me just to look at them. (Where there is one particular person who produces that emotional reaction in you.)

Exercise

Let's have a look at the basic list of five unhelpful beliefs. In each of the following examples, underline the answer which you think is best. In some cases there may be more than one possibility, in those cases underline more than one. The first two have been completed for you.

1 Steve, Ben and Chris are all sitting in a bar, near to the door. During the course of the evening four people come in and leave the door open. When the fifth person comes in it is Steve who gets angry.

This is because Steve believes that things should be just how he wants them / **believes people take no notice unless you are irritated or angry** / **believes people are selfish, self-centred and unhelpful** / believes people are hostile and constantly trying to put you down / believes if people do wrong they must be punished, you can't let people get away with things.

2 In a particular street in a medium-sized town there are seventeen mothers who have youngsters between the ages of 5 and 15. All those youngsters, to a greater or lesser degree, drop mugs on the floor from time to time.

Sue gets much angrier than any of the other sixteen because **she believes that things should be just how she wants them** / **believes people take no notice unless you are irritated or angry** / believes people are selfish, self-centred and unhelpful / believes people are hostile and constantly trying to put you down / believes if people do wrong they must be punished, you can't let people get away with things.

3 Nigel's wife has a habit of contradicting him when they are out in public. This makes him very angry because he feels he 'loses face' in front of other people.

This is because he basically believes that things should be just how he wants them / believes people take no notice unless you are irritated or angry / believes people are selfish, self-centred and unhelpful / believes people are hostile and constantly trying to put you down / believes if people do wrong they must be punished, you can't let people get away with things.

4 Alan, the electrician, feels really 'put upon' and angry when his boss asks him to do extra tasks towards the end of the day.

He tends to see his boss in this light because he basically believes that things should be just how he wants them / believes people take no notice unless you are irritated or angry / believes people are selfish, self-centred and unhelpful / believes people are hostile and constantly trying to put you down / believes if people do wrong they must be punished, you can't let people get away with things.

5 When Fiona flirts with other men it makes her husband, Graham, very angry. On the other hand, when Hannah flirts with other men, her husband Ian does not get angry.

The difference between the two men is that Graham basically believes that things should be just how he wants them / believes people take no notice unless you are irritated or angry / believes people are selfish, self-centred and unhelpful / believes people are hostile and constantly trying to put you down believes if people do wrong they must be punished, you can't let people get away with things.

6 One evening in November 1999 a total of around one million people drank in a British pub. Of that one million people, about 10,000 were jogged so that they spilt their drink over themselves. Of those 10,000, Brian was the only one who broke a beer mug and pushed it in the face of the person who jogged him.

Part of the reason he reacted so badly is that he believes that things should be just how he wants them / believes people take no notice unless you are irritated or angry / believes people are selfish, self-centred and unhelpful / believes people are hostile and constantly trying to put you down / believes if people do wrong they must be punished, you can't let people get away with things.

7 On a particular estate in a particular city there are around 600 children between the ages of five and fifteen. Only about fifty of them keep their rooms tidy enough to satisfy their parents. Most parents on this estate nag their children to keep their rooms tidier. Anne, on the other hand, completely 'loses her cool' with her twelve-year-old daughter.

This is because Anne believes that things should be just how she wants them / believes people take no notice unless you are irritated or angry / believes people are selfish, self-centred and unhelpful / believes people are hostile and constantly trying to put you down / believes if people do wrong they must be punished, you can't let people get away with things.

8 Paul feels terrible because he hit his twelve year-old son across the face because the boy hadn't done his homework and had lied to him about it.

However, Paul was prone to react this way because deep down he believes that things should be just how he wants them / believes people take no notice unless you are irritated or angry / believes people are selfish, self-centred and unhelpful / believes people are hostile and constantly trying to put you down / believes if people do wrong they must be punished, you can't let people get away with things.

9 Another driver cut across Chris' path as he was going round a roundabout. He got so angry that he 'tailgated' the other driver for five miles. Eventually, the other driver got out and confronted Chris, and there was a fight during which Chris came off very much second best.

Chris would never have behaved this way in the first place had he not believed that things should be just how he wants them / believed people take no notice unless you are irritated or angry / believed people are selfish, self-centred and unhelpful / believed people are hostile and constantly trying to put you down / believed if people do wrong they must be punished, you can't let people get away with things.

How did you get on? Below is the same list of my own answers. Some of them are

certainly debatable, but at least they will give you food for thought.

1 Steve, Ben and Chris are all sitting in a bar, near to the door. During the course of the evening four people come in and leave the door open. When the fifth person comes in it is Steve who gets angry.

This is because Steve believes that things should be just how he wants them / believes people take no notice unless you are irritated or angry / **believes people are selfish, self-centred and unhelpful** / believes people are hostile and constantly trying to put you down / **believes if people do wrong they must be punished, you can't let people get way with things.**

2 In a particular street in a medium-sized town there are seventeen mothers who have youngsters between the ages of five and fifteen. All those youngsters, to a greater or lesser degree, drop mugs on the floor from time to time.

Sue gets much angrier than any of the other sixteen because **she believes that things should be just how she wants them** / **believes people take no notice unless you are irritated or angry** / believes people are selfish, self-centred and unhelpful / believes people are hostile and constantly trying to put you down / believes if people do wrong they must be punished, you can't let people get way with things.

3 Nigel's wife has a habit of contradicting him when they are out in public. This makes him very angry because he feels he 'loses face' in front of other people.

This is because he basically believes that things should be just how he wants them / believes people take no notice unless you are irritated or angry / believes people are selfish, self-centred and unhelpful / **believes people are hostile and constantly trying to put you down** / believes if people do wrong they must be punished, you can't let people get way with things.

4 Alan, the electrician, feels really 'put upon' and angry when his boss asks him to do extra tasks towards the end of the day.

He tends to see his boss in this light because he basically believes that things should be just how he wants them / believes people take no notice unless you are irritated or angry / **believes people are selfish, self-centred and unhelpful** / believes people are hostile and constantly trying to put you down / believes if people do wrong they must be punished, you can't let people get way with things.

5 When Fiona flirts with other men it makes her husband, Graham, very angry. On the other hand, when Hannah flirts with other men, her husband Ian does not get angry.

The difference between the two men is that Graham basically **believes that things should be just how he wants them** / believes people take no notice unless you are irritated or angry / believes people are selfish, self-centred and unhelpful / **believes people are hostile and constantly trying to put you down** / believes if people do wrong they must be punished, you can't let people get way with things.

6 One evening in November 1999 a total of around one million people drank in a British pub. Of that one million people about 10,000 were jogged so that they spilt their drink over them. Of those 10,000, Brian was the only one who broke a beer mug and pushed it in the face of the person who jogged him.

Part of the reason he reacted so badly is that he believes that things should be just how he wants them / believes people take no notice unless you are irritated or angry / believes people are selfish, self-centred and unhelpful / believes people are hostile and constantly trying to put you down / believes if people do wrong they must be punished, you can't let people get away with things.

7 On a particular estate in a particular city there are around 600 children between the ages of five and fifteen. Only about fifty of them keep their rooms tidy enough to satisfy their parents. Most parents on this estate nag their children to keep their rooms tidier. Anne, on the other hand, completely 'loses her cool' with her twelve-year-old daughter.

This is because Anne believes that **things should be just how she wants them / believes people take no notice unless you are irritated or angry** / believes people are selfish, self-centred and unhelpful / believes people are hostile and constantly trying to put you down / **believes if people do wrong they must be punished, you can't let people get away with things.**

8 Paul feels terrible because he hit his twelve year-old son across the face because the boy hadn't done his homework and had lied to him about it.

However, Paul was prone to react this way because deep down he believes that things should be just how he wants them / **believes people take no notice unless you are irritated or angry** / believes people are selfish, self-centred and unhelpful / believes people are hostile and constantly trying to put you down / **believes if people do wrong they must be punished, you can't let people get away with things.**

9 Another driver cut across Chris' path as he was going round a roundabout. He got so angry that he 'tailgated' the other driver for five miles. Eventually, the other driver got out and confronted Chris, and there was a fight during which Chris came off very much second best.

Chris would never have behaved this way in the first place had he not believed that things should be just how he wants them / believed people take no notice unless you are irritated or angry / believed people are selfish, self-centred and unhelpful / **believed people are hostile and constantly trying to put you down / believed if people do wrong they must be punished, you can't let people get away with things.**

And you can see the terrific pay-off that each of these people would receive if only they could alter their beliefs. For example:

1 Not only would Steve not be angry when somebody leaves the bar door open, he would not get so angry when somebody got served ahead of him in the queue, when Ben doesn't buy a round of drinks when it's his turn, etc. (Importantly, this is not to say that Steve will not rectify these things, just that he won't get angry about it.)

2 Sue will not only remain calm when her son drops a mug on the floor, she would also remain calm when he forgot to take an essential item to school. (Again, this is not to say that she would not try and develop his taking more care over things.)

3 If Nigel could change his beliefs he would feel much easier about his wife

contradicting him in public because he wouldn't anticipate a critical reaction from other people. Equally, he would feel much more relaxed in a whole host of social situations for exactly the same reason.

4 If Alan, the electrician, could alter his belief that other people are always likely to be trying to take advantage of him, then he would feel less put upon when his boss asked him to do extra jobs. Equally, he would feel more relaxed in other situations too.

5 If Graham could realize that other people (including his wife Fiona, and the men she flirts with) are not always trying to put you down, he would feel much more relaxed about her playfulness. Equally, he would feel much more relaxed in a whole host of other situations.

6 The same applies to Brian. His belief that other people are hostile and likely to be putting you down resulted in very serious consequences for him when he put a broken beer mug in the face of the person who jogged his elbow. Not only could those consequences have been avoided but, had he realized that most people are not hostile in this way, he would have lived a much more relaxed and enjoyable life.

7 Anne got extremely angry with her twelve-year-old daughter because she didn't tidy her room, and Anne believes that things have got to be the way she wants, and that people take no notice unless you get angry with them. She too would be leading a much more enjoyable life if she could accept that, by and large, things tend not to be quite how you would like them to be, but this *doesn't really matter*. And anyway, people are better 'developed' by constructive interactions rather than by getting angry with them.

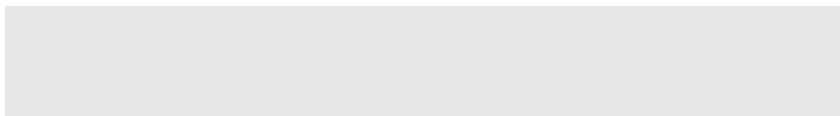
8 A similar kind of thing applies to Paul, who hit his twelve-year-old son across the face. If Paul could get to realize that it's not the end of the world if things aren't just how he wants them to be and that's it's probably not true that people take no notice unless you get really angry with them, he wouldn't have done this. Equally, he stands to benefit in all sorts of situations if he can remedy those beliefs.

9 Things worked out very badly for Chris after somebody cut across his path on a roundabout and he eventually came to grief in a fight with the other driver. If only he hadn't believed that people must be punished if they do something wrong he could have avoided this. But again, this is only one example of Chris constantly giving himself a bad time because he believed that. Equally, he stands to benefit in all sorts of situations if he can remedy those beliefs.

Developing more helpful beliefs

For this we use the AA method – which, in this case, has nothing to do with too much alcohol consumption. Here it stands simply for (a) developing better Alternative beliefs and (b) Acting them out.

Here are some suggestions:



- Less helpful belief: Things should be just exactly how I want them to be. It is awful if they are not.
- Suggestion for more helpful alternative: It's nice if things are just the way I want them, but it's not the end of the world if they're not.
- Less helpful belief: People don't take any notice of you unless you show that you are irritated or angry. It is the only way of making your point.
- Suggestion for more helpful alternative: Although you can sometimes get people to do what you want by being irritable and angry with them, you never really get them on your side. So it's better to talk and persuade. Even then people won't always do what we want, but that's not the end of the world either.
- Less helpful belief: Other people are basically selfish, self-centred and unhelpful. If you want them to help you, you have to *make* them.
- Suggestion for more helpful alternative: Although there are some people who are very selfish indeed, most people will help each other out if asked.
- Less helpful belief: Other people are basically hostile. You have to be on the alert otherwise they will take any opportunity to put you down.
- Suggestion for more helpful alternative: Although there are a few people who can be quite hostile, most people basically support each other and take a good view of each other.
- Less helpful belief: If people do wrong they must be punished, you can't let people get away with things.
- Suggestion for more helpful alternative: It's better to persuade than punish, to look to the future rather than the past. Sometimes you can't even persuade and people do get away with things. So, I'll just keep up my own standards.
- Less helpful belief: It's okay to get angry with/hit policemen, bouncers, etc.
- Suggestion for more helpful alternative: Policemen, bouncers etc. are actually real people just like anybody else. It's no more reasonable to hit them than to hit any other person.
- Less helpful belief: A father/mother/foreman/ manager/supervisor is *meant* to be snappy, irritable and harsh. (Where you are a father/mother/foreman/manager/ supervisor.)
- Suggestion for more helpful alternative: A father/ mother/foreman/manager/ supervisor needs to set a good example. That means being friendly and supportive rather than irritable and angry.
- Less helpful belief: My father/mother/partner/son/ daughter is a complete pain in the neck, it irritates me just to look at him/her. (Where there is one particular person who produces that emotional reaction in you.)
- Suggestion for more helpful alternative: My father/ mother/partner/son/daughter is just like anybody else – they've got their good points and bad points. It's no use getting hung up on their bad points.

Use cue-cards if you want

Some people actually write out a small card for themselves (known as a cue-card). This has the unhelpful belief written on the one side and a more helpful alternative on the other. Sometimes people will make quite elaborate versions of these. For example, you might write the unhelpful version in red (for danger) and the more helpful version on the other side in green (for 'go'). And you might perhaps add an exhortation after the helpful version, like 'Now do it!' Some people even go off to their local print shop and get the card nicely laminated once they have got it just how they want! Whether you like your card basic or exotic, it's quite a nice idea to carry it around with you as a constant reminder. You probably won't need seven cards – it's unlikely that you are falling prey to all seven of the unhelpful beliefs, probably just one or two – in which case you just need one or two cards.

Acting it out

You will probably remember that we noted in the previous chapter that *thinking* differently is not enough. You also need to *act* on your new thoughts. New thoughts and new behavior make a terrifically powerful combination. Rather in the way that two bicycles can lean against each other and prop each other up in a perfectly stable way for ever, your new thinking is supported by your new behavior and, equally, your new behavior is supported by your new thinking. The two will constantly reinforce each other. It's the closest we are ever going to get to perpetual motion.

So how do we act it out? There are a couple of possibilities:

- Simply imagine how a person with the new, more helpful alternative belief would act and mimic that.
- Find yourself a role-model. In other words, think of somebody who acts like they believe the new improved belief, imagine what they would do, and do it.

In either case you have to do it with a degree of conviction. For example, Sue of the mug-dropping teenage son needs to really work on her belief that he is basically okay (rather than fundamentally selfish), and she would do well to set an example of friendliness and helpfulness (rather than being like a stropky foreman) and really act like she *believes* these two new beliefs. So, rather than uttering the words 'Get a brush and sweep it up' through clenched teeth (which, admittedly would be an improvement over her previous behavior), she goes the whole hog and says 'Get a brush and sweep it up, there's a good boy,' complete with matching encouraging tone. The point is that what she is aiming for is not simply to tidy up her behavior so that it's not so wearing for her and everybody else, but to have her new, more helpful behavior in line with new, more helpful underlying beliefs, so that she is genuinely at peace with herself and other people can see that. This is clearly much better for all concerned than simply 'keeping the lid on it'.

In just the same way Steve, sitting near the door of the bar, will now realize that the five individuals who left the door open are not selfish scoundrels who deserve punishment, but perfectly okay individuals who just need to be reminded to shut the door. The way he asks them to do that will therefore be friendly and calm, in line with that belief.

Likewise, Nigel, whose wife contradicts him in public, will realize that although others might laugh when this happens, this does not indicate that they are fundamentally hostile to him, because people are mostly supportive and friendly. Acting it out, he can now join in the laughter.

Similarly Alan need not get himself into a stew by distressing himself over things not being just as he would like them to be. He can simply get on and do the job the boss asks, or not. What was winding him up was how awful it was that things were not as he would wish. Now he's resigned to that fact he can simply get on with things.

Fiona's flirting need not irritate Graham now that he accepts that neither Fiona nor other people are basically hostile, but rather that most people are friendly and supportive; he can take Fiona's behavior for the harmless amusement it is, and act things out by just joining in the fun.

Brian, too, had he accepted that most people are okay rather than hostile, would not have jumped to the conclusion that his elbow was joggled deliberately at the bar. He would have assumed it was an accident, possibly made a joke out of it, and might

even have got himself a free pint.

Anne would not have lost her rag with her daughter, sitting in the bath not tidying her room. Rather than being so uptight because things were not as she would wish (the room was still untidy) and determined that the girl must be punished for her misdemeanour, she could have accepted that sometimes children have untidy rooms and that anyway her best option is to be setting a good example as a parent.

Nor need Chris have gone chasing the man who cut across his path on the roundabout. If only he had accepted that people do not need to be punished for their misdemeanours, and that sometimes they even get away with them, he could have simply acted this belief it out by keeping up his own standards and driving his car as he thinks cars should be driven – and saved himself a lot of trouble.

A role-model can be helpful

We can see from these examples that it is straightforward enough to decide on a new belief and act it out in daily life. Plenty of people do that with a lot of success and a lot of pleasure. (It is very satisfying to see yourself take charge of your own destiny, decide on sensible beliefs and act in line with them.) Other people get to exactly the same destination by a different route. They think of a particular person who seems to believe the kind of beliefs we have spoken about and ask themselves, ‘What would s/he do in this situation?’

For some people, imagining it makes it a lot easier to mimic it. And mimicking the behavior effectively consolidates the new beliefs.

The role-model can be somebody you know, like a friend or relative, or it can be somebody you’ve never actually met – someone you’ve seen on television, perhaps. One important point if you use the latter: it doesn’t particularly matter if the person is like their screen persona or not. For example, my two favourite role-models are the television business troubleshooter John Harvey-Jones and ace cricket commentator Brian Johnston. Now, I’ve never met either of these good people, and for all I know they might have been quite different in private life from their genial demeanour on television and radio. As a matter of fact, both gentlemen are, or were – Brian Johnston sadly died a few years back – by all accounts much the same in private life as they appeared in the public eye. But my point here is that it doesn’t matter; for the purpose of a role-model, it is the persona you recognize that is important.

Nor do your role-models have to match you in age or gender, or anything else. All that is important is that you can ask yourself: ‘What perspective would s/he have taken on this?’ and ‘How would s/he have behaved in this situation?’ and so on. The fact that I never quite live up to either of my models doesn’t matter either; they certainly have a good effect. The key thing is that if you find yourself a good role-model s/he can lead you into behaving just how you would wish to.

Reviewing and recording

Just as in the previous chapter, reviewing and recording are great habits to get into in entrenching your new and more helpful beliefs.

‘Reviewing’ is literally looking again at the situation that has just passed and replaying it. You may be in the happy situation where you can enjoy reviewing how well you behaved, how well you brought into play your new beliefs and meshed them

with splendid new behavior. In which case, terrific: enjoy every moment of it. And it's not just enjoyment, either; it is, as we said before, a very useful activity to review things that have gone right. When things go well you have a good template for future success, so it is useful to consolidate and examine that template. If you've handled a difficult situation well, with no irritability and anger, then go back over it, review it, enjoy the moment.

Equally, if you've handled a situation badly in your view, if you've given in to some unhelpful beliefs and matched them with irritable and angry behavior, then simply replay the situation how you think it should have gone. Remember to think the more helpful beliefs, and envisage the more helpful behavior. *That replaying of the situation the way you would have preferred it to have gone is an extremely good thing to do*; it makes it more likely that it will go that way next time. (But beware: it is rather unhelpful simply to replay your *wrong* handling of the situation. It's best to regard that as 'water under the bridge'.)

SUMMARY

- In this chapter we have covered how our beliefs affect the way we appraise and judge a situation, and as a consequence how we behave in that situation.
- We have listed the most common unhelpful beliefs that affect people's perceptions of the situations in which they find themselves.
- We have listed the more helpful alternative beliefs to replace the unhelpful ones.
- We have looked at the method for replacing unhelpful beliefs with helpful ones. This involves the AA method: highlighting the Alternative helpful belief and Acting out the situation in line with those beliefs.
- We have looked at the importance of reviewing successes and consolidating them as templates for good future behavior, and also of reviewing failures – but reminding ourselves how we would have preferred to act in the situation, so we are more likely to get it right next time!

PROJECT

- Get yourself a piece of paper and write down any of the unhelpful beliefs that you think apply to you.
- For each of them, write down the more helpful belief. This might be a question of simply copying down what I've written above, or you might want to put it into your own words.
- Replay a recent situation where your unhelpful beliefs have led you to appraise a situation badly and react in an irritable and angry way. Replay how you would have seen the situation if you had had your more helpful beliefs in place, and what you would have done. (For example, if you are Steve you would replay sitting at the bar by the door, now believing that people, even those who leave doors open, are basically okay, appraising the situation differently and asking, in a proper friendly way, each person to close the door). Make it a good vivid replay in your mind.
- Most important of all, practise your new beliefs, seeing every situation through the eyes of someone who has these new beliefs, or through the eyes of a role-model you've settled on. Then match your behavior to your new perceptions – just as Steve would do in the previous point.
- Each time you have success, review that success and enjoy the moment. Review how your new beliefs helped, and how your new behavior was in line with those beliefs. If you 'let yourself down', review the incident *the way you would have preferred it to have gone*. Pretty soon you will have lots of 'good' reviews and not many of the other sort!

Cats, camels and recreation: Anger

Daft title for a chapter. Never mind, you might as well read it because it could just be very relevant to yourself. For some people it will be spot-on.

Remember the model we're working on as trigger, appraisal/judgement, anger, inhibitions, response (see Figure 12.1). What we are talking about in this chapter is the 'anger' box; and there are just three points to make about it.

Displacing anger

The first point is that *anger can be displaced*. This process is commonly known as 'kicking the cat' or 'always hurting the one you love'. For example, you may have a bad day at work, but judge that it is a bad career move to get angry with your boss. What you do, therefore, is to come home and (metaphorically, of course!) kick the cat: in other words, take it out on whoever or whatever happens to be around.

The strange thing is that whoever or whatever turns out to be on the receiving end of your anger does in fact seem to be very irritating at the time in question. You are not always aware that you are 'displacing' your anger from your boss at work on to your loved ones/cat at home.

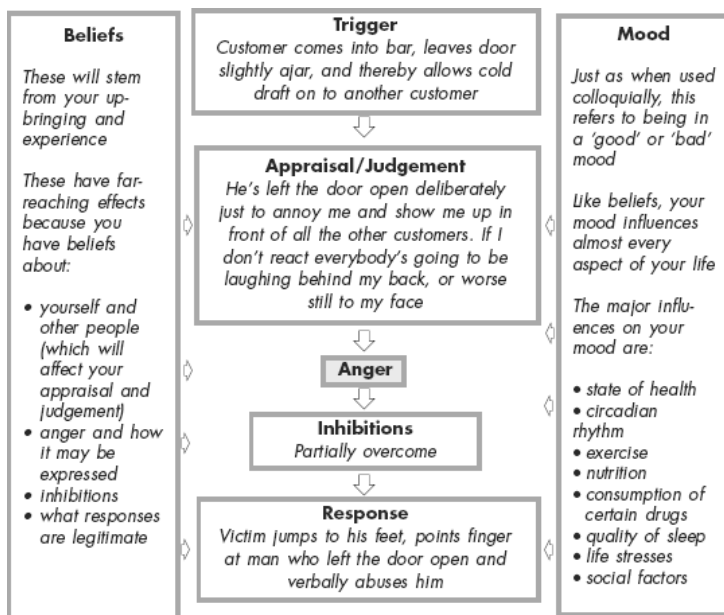


Figure 12.1 A model for analyzing irritability and anger

Anger is additive

The second point is that *anger is additive*: it builds up. Again, the best analogy is the leaky bucket that we first used in Part One. Suppose you have a bucket with holes in it; it is still possible to fill the bucket to overflowing by pouring in several jugs of water in quick succession. When the bucket overflows, that's the equivalent of an outburst of anger or irritability.

So, if five people come into the bar within the space of an hour or two and each one leaves the door open causing a draft, the bucket overflows (or at least it does in Steve's case) and an outburst occurs. If those same five people came into the bar over a six-month period, and on each occasion Steve was sitting near the door, it is unlikely that he would have an outburst on the fifth occasion. This is because his anger would have been given a chance to 'leak away' on each occasion before the next 'top-up'.

This 'building up' is commonly known as the 'last straw that breaks the camel's back' phenomenon. I prefer the image of the leaky bucket, however, because, given half a chance, your anger will normally 'leak away' quite nicely.

Recreational anger

The third point to be made here, and perhaps the most important one, concerns what I call 'recreational anger'. Let me give you an example. Please don't be put off by the fact that this is a very extreme example; the same phenomenon happens day in, day out.

Very early on in my career, when I was working as a prison psychologist, I came across a prisoner who was having quite a lot of trouble serving his sentence; he got tense and agitated, and periodically smashed up his cell. I taught him how to relax and did some general ‘counselling’ work with him, with the result that he confided in me that he had been beaten up by half a dozen prison officers in the previous prison he had been held in. (I have no idea how true this allegation was, but that was what he told me.)

Anyway, he’d formed a plan that, on release, he would go and track down these six prison officers, and one by one shoot them.

I took this very seriously, (a) because I was young and naïve and took everything seriously, and (b) because he was already in prison for having shot somebody, so clearly he had the wherewithal to do what he said he was going to do. Furthermore he described how, on his previous sentence, he had done exactly the same thing: that is, he had spent time thinking and planning about how, when he got out, he would shoot this person. And, sure enough, he had done exactly that, and here he was back in prison again for that crime.

Now, it would be nice to think that young prison psychologists know exactly what to do in such a situation, but I have to tell you that I didn’t. So we simply got to talking around it, him telling me all about how it was . . .

To cut a long story short, he was in the habit of whiling away hour after hour fantasizing about how he was going to get his revenge. This, apparently, was entirely pleasurable, and time flew by while he did this.

And this was the first case I came across of ‘recreational anger’: anger which at the very least passes the time of day, sometimes actually gives you a ‘buzz’ and often puts you into a different state of mind, so that actions which wouldn’t normally seem sensible and rational options look like just that. Going back to our leaky bucket analogy, it is as though you’ve plugged up all the holes in the bucket, keen to hang on to all the water there, and then just spend the time looking at the water. Or, rather more literally, you do everything to prevent your anger from drifting away and spend time mulling it over.

The best course of action to take in this situation is as follows:

- Don’t do whatever your anger is telling you to do.
- Do something else.

Let’s expand on that a little. When you are very irritable and angry it is as though that anger takes you over. The anger actually tells you to do things that, in your normal state, you wouldn’t do. So who are you going to take more notice of, your anger or you yourself?

Well, the answer is obvious: it’s more important to be true to yourself than to some temporary state of anger. On the other hand, it is very difficult simply to *refrain* from doing something. Rather like ‘not thinking of a giraffe’, it is virtually impossible. If someone tells you *not* to think of a giraffe, a picture of a long dappled neck springs into mind no matter how carefully you try to obey. In the same way, not to do what your anger tells you is very tricky indeed.

Getting away from anger

The answer is to *concentrate on doing something else*. Anything. Real-life examples of alternatives that people turn to in this situation include the following:

- Take physical exercise: walk, run, swim, etc.
- Read a book, magazine, newspaper.
- Watch television or listen to the radio.
- Go and do some gardening.
- Phone up or go and see a friend.
- Simply take yourself out of the situation and go somewhere else.

All of these are equivalent to ‘doing something else’. And that is sufficient for most of us. In the case of the prisoner I was just telling you about, tactics such as reading a book would not be sufficient, because he had a long-term problem, ten times the size of anything afflicting most of us. Nevertheless, with him, we adopted exactly the same strategy, and he did indeed ‘do something else’. He got in touch with a woman who ran a hostel for ex-prisoners and wrote to her to see whether that was somewhere he could stay after release. Thank goodness, she wrote back telling him that might well be an option and, most importantly, including a photograph of the actual hostel. I am sure that it was that photograph that really swung it for him. Now he could literally envisage what else he could do upon leaving prison. Rather than going up to his previous prison and slowly stalking the six prison officers concerned, he could catch a train to this hostel and settle there. Happily, it was in a totally different part of the country.

Well, all that sounds very sensible, doesn’t it? So why don’t people do it? When you feel really angry and your anger is telling you to do something drastic, why do you tend to do it even though the rational part of you knows that this is a temporary state you’re in?

I think one of the reasons is that some people think it is more ‘honest’ to give vent to their anger. Personally, I wouldn’t go along with that. ‘Honesty’ is a splendid characteristic when it means (a) not lying or (b) not stealing from other people, but a very destructive characteristic when it is used to mean (c) saying very tactless and hurtful things on the grounds that ‘I’m only being honest’ or (d) simply giving vent to angry urges without any thought of the consequences for yourself or other people.

Give yourself time

There’s one important reason why it is always sensible, first, to refrain from doing what your anger is telling you, and second, to do something else. This is because, once you have truly regained your emotional equilibrium, you can decide at leisure what you think is best to do about the situation, rather than letting your anger tell you.

Let me give you an example. Graham described to me how on one occasion he was so agitated by his wife Fiona’s flirting that, even while still at the party they were both attending, he was going through in his mind how he was going to leave Fiona and, more particularly, how he was going to tell Fiona about his decision. He was relishing, in a strange sort of way, how this would ‘teach her a lesson’ and how sorry she would be.

And it was more by luck than judgement that this did not come to pass. In the car

going home he was ‘sulking’ but in fact still rehearsing what he was going to say and still enjoying the anticipated effect. At home, the sulk continued but, as I say, more by luck than judgement he decided to postpone the confrontation until the next morning and simply go to sleep for the time being. Happily, by the next morning sleep had worked its magic, anger had retreated to a back seat and, although the discussion was rather heated, it was not so vitriolic as it would have been the previous evening. So, by accident, Graham had followed the formula: Don’t do what your anger tells you, do something else (in this case, go to sleep).

Graham is one of my favourite cases, for two reasons. First, there are lots of Grahams who have not worked things out so well for themselves: in other words, men who have allowed their anger to tell them what to do and whose marriages have disintegrated as a result. Second, in Graham’s case, he was able eventually to do a complete review of his judgements and beliefs, rather along the lines of that set out in the previous two chapters, and ended up seeing things in a completely different light. The net result was that Fiona’s flirting did not simply become ‘not irritating’, it became a positive asset to their relationship once he realized that it was perfectly harmless, and, perhaps more to the point, that everybody else knew that it had no serious intent.

SUMMARY

- In talking about anger there are three points to be made. First, it can be displaced so that, although it might be your boss who has caused your anger, your partner or somebody else actually receives it. Second, anger is *additive* by nature. Envisage your anger as water in a leaky bucket. If another jug full of anger arrives before the first jug-full has been allowed to leak away, then your bucket is filling up. Eventually, if a third, fourth or fifth jug-full arrives, the bucket might overflow, leading to an angry outburst. Third, there is such a thing as ‘recreational anger’, where you get a peculiar kind of buzz from simply dwelling upon your anger and what you’re going to do about it.
- Probably the best analogy for anger is the ‘leaky bucket’. If it is topped up too quickly, then yes, it can overflow; but given half a chance, anger will leak away over a period of time.
- No matter whether your anger is about to overflow, or whether you’re in a state of recreational anger, or *anything* else, the best policy is (a) don’t allow your anger to tell you what to do and (b) do anything else. Only when you’ve gained a good sense of equilibrium should you decide what to do about the situation that prompted the anger.
- The use of a role-model (a person you use as a good example), as discussed in Chapter 11, can be very powerful here. You can simply ask yourself ‘What would X [your model] do right now?’ Interestingly, your anger will fight back and tell you to get on with allowing it to have its head. Just put it on hold for a moment, and really get to imagining what your good role-model would do in the given situation.

PROJECT

- One of the most important lessons in this chapter has been how to differentiate between what your anger tells you to do and what you yourself want to do. Therefore a very relevant project is to work on becoming more aware of both of these ‘voices’. What I mean is, next time you are feeling angry, work out (a) what your anger is telling you to do and (b) what your ‘real self’ would tell you to do.
- It’s good to practise this in situations which make you only *slightly* angry. The reason for this is that when you are very angry the ‘angry voice’ shouts so loud that it drowns out your ‘true self’ voice. You therefore have to practise being attuned to your ‘true self’ voice in mild-anger situations so that, eventually, you can hear it even in high-anger situations.
- And remember, most of us want to be loyal to our true self rather than to what anger tells us to do.

Putting the brakes on: Inhibitions

As we have said before, some people view inhibitions as bad things to have. They think in terms of 'being inhibited', equating it with being shy, withdrawn and a shade socially inadequate.

In our context the reverse is the case. Remember where the inhibitions box fits into our model (Figure 13.1).

The point here is that anger is an emotion which we may or may not choose to make other people aware of. So it is perfectly possible for somebody to be angry with you without you realizing it, simply because they choose not to tell you or not to demonstrate it in any way. And, of course the reverse holds true as well: it is perfectly possible for you to be feeling very irritable and angry and for other people to be totally unaware of it. This rather useful phenomenon is all thanks to our inhibitions. It is no accident that there is an area of the brain whose specific function is to inhibit the expression of every emotion that might occur.

This area of the brain can be damaged temporarily, for example by alcohol, or permanently by injury or some illnesses. Happily, however, it can also be developed. In this chapter we will look at inhibitions, why we want to use them, and how we can develop our ability to use them.

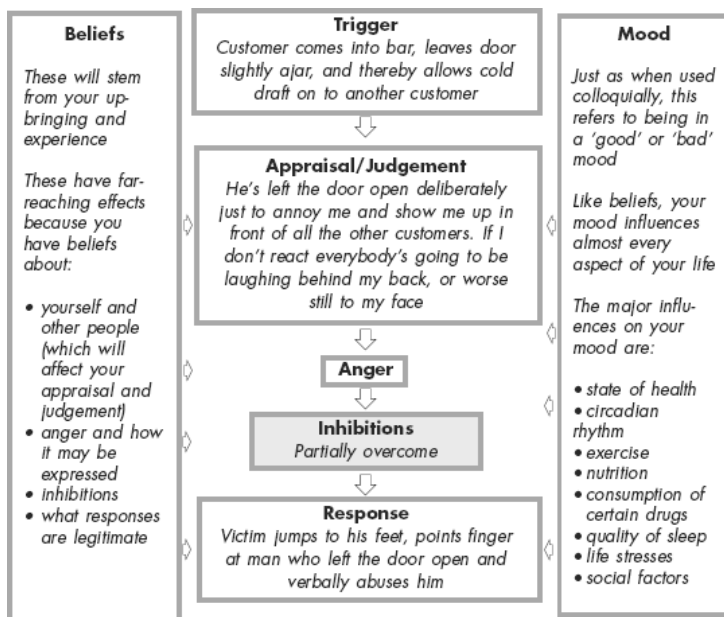


Figure 13.1 A model for analyzing irritability and anger

Internal and external inhibitions

Inhibitions fall into two categories:

- moral, or 'internal' inhibitions;
- practical, or 'external' inhibitions.

Leaving aside how we bring these inhibitions to mind at the crucial time just for the moment, let's have a look at each of these categories.

Moral inhibitions

Some examples of moral inhibitions are

- 'It is wrong to go around snapping at people.'
- 'It is wrong to be frequently angry with people.'
- 'It is wrong to hit people.'

. . . and so on. Over thousands of years philosophers have given a lot of thought to what makes actions moral or otherwise, and various schemes have been proposed. One such is the 'What if everybody did this?' argument, and this is probably one of the more relevant ones here. If everybody goes around snapping at one another, being angry with one another, hitting one another, then clearly the world is going to be an extremely unrewarding place. Therefore, if it is not okay for everybody to do it, how

can it be okay for you to do it?

Another basis for morality is the 'adhering to set rules' scheme, of which the Ten Commandments is one example. And this is indeed a powerful constraint on people's behavior. We all set ourselves rules which control our behavior – down to the finest detail, sometimes. Some of these rules can be very strange and even abhorrent. For example, there are men who hold to the rule that 'You never hit a woman, unless you're living with her.' Now what possible ethical basis can such a rule have? None that I or the majority of people can see; but even so, this rule governs the behavior of some men.

Some rules are imposed on us by society and most of us sign up to them. Examples include 'You don't stab people,' 'You don't shoot people,' and 'You don't hit people.' But of course, not everybody signs up to all of these rules. Most people sign up to the first two of those three, but a significant number do not sign up to the third. I say that simply because many parents hit their children, although they usually use a euphemism such as 'slap' or 'smack' or 'spank'.

Once you start setting rules for yourself, over and above those that society imposes, then things can get surprisingly complicated, especially in view of the fact that this should be a fairly simple business. For example, before our children were born, my wife and I set a rule for ourselves that we would never hit them. A good rule, we thought, and indeed we have abided by it. But even this has major snags, which I will tell you about.

Just before I do, though, I would like to you to contemplate an incident I witnessed walking through the pedestrian area of a city centre. Nearby, a woman was walking along with her two children of perhaps eight and ten. As they walked along, she was hitting one of them backwards and forwards across the head, saying to him as she did so: 'How many times have I told you not to hit your brother?'

The contradictory nature of the mother's words and behavior somehow produced an almost humorous side to this sorry sight. Nevertheless, the 'Give him a taste of his own medicine' thinking that she was demonstrating is common enough. Sadly, however, the all-powerful effect of modelling will probably overwhelm everything else. The young lad will be left with the simple observation that 'It is okay to hit people, even my mother does it.'

But back to my own dilemmas. There we were, smugly bringing up our kids without hitting/smacking/slapping them. And did this mean that they behaved like angels? No, of course it didn't; in fact they behaved just like all other kids. For example, when young, they would shout, squabble, pinch and hit each other. Shout, in particular. So how did I resolve the situation, how did I intervene to stop them shouting and quarrelling? Well, naturally, I shouted louder than either of them.

This usually worked in the short term, but was it a good policy? Clearly not, because I was simply doing exactly the same as I had seen the woman in the pedestrian area doing: trying to quell a behavior by exhibiting exactly the same behavior. So what lesson would my children learn? Presumably 'It's okay to shout, even my father does it.'

'Modelling' is the key concept here. This simply refers to the 'model' or 'example' you set. And in the case of parents and children, the example set is a very powerful one.

Here's another instance of the power of rule-setting. Richard was a young man who had come to see me because he had taken to terminating arguments with his

girlfriend by hitting her. The sequence of events seemed to be that they would start arguing, both would start shouting at each other, and the process would only come to an end when he hit her. He then felt terribly guilty, she felt terrible, and this was putting an understandable strain on the whole relationship. And yet, he seemed unable to stop. This was surely strange; one might say, 'If he doesn't want to do it, why doesn't he *stop* doing it?' But, as so often is the case, he seemed to be the victim of his own behavior. Richard was unable to help himself and so turned to outside help through therapy.

Richard and I talked about his background and he told me about his school and college days (which weren't long ago; he was only in his early twenties at the time). In particular he told me how he seemed to be a natural target for bullying. Even in his last year at school a particular fellow student used to pick on him. On one occasion this youth picked on him once too often and, probably accidentally, ripped his shirt. Richard told me how, when this happened, something snapped inside him. Apparently uncontrollably, he just grabbed hold of his tormentor and gave him a thorough pummeling. Unsurprisingly, perhaps, this put an end to the whole sad sequence of events. Not only did the tormentor stop tormenting Richard, he also seemed to be genuinely remorseful.

Equally unsurprisingly, Richard felt rather pleased with himself; it seemed that he had discovered the answer to many of life's problems, although in fairness he did not phrase it consciously and openly to himself in this way. Nevertheless, it was about six months after that incident that he first hit his girlfriend. And from then on there was no turning back; the pattern was established.

So the question is: What rule had Richard established for himself? It seemed to be something like: 'It's okay to hit people, in fact it will solve a lot of problems.'

And yet, when we examine the evidence, this only seemed to be partially true. In the one instance, leaving aside as to whether Richard was 'right' to hit the other guy, it had worked well for him. With his girlfriend, it was working very badly for both of them.

I asked him to try out a new rule, namely: 'It's sometimes okay to get into fights with males my own age, but no one else.' He tried it out, experimentally at first; then, gradually, he 'bought into' the rule and really adopted it as his own. On his subsequent appointments he came with his girlfriend, and they told me this new approach was working very well for them. (Incidentally, happily Richard did *not* then go around getting into fights with males his own age. In fact, he seemed to be naturally a very peaceable kind of character.)

So, we have a first category of inhibitions, the moral category. These inhibitions may be established by the question 'What if everybody went around doing this?' This principle will tend to preclude us from indiscriminately snapping, shouting, hitting. The other yardstick for these moral inhibitions is 'obedience to a rule'. Many rules are the laws of the land and it's obviously best to go by those. Others, like not hitting children, we make up for ourselves. Even so, they are very powerful determinants of our behavior. I mentioned in an earlier chapter the man at the bar who stopped himself being hit by saying to his would-be assailant, 'Hey, I'm over forty.' By the time the would-be assailant checked through his list of rules to see whether there was one which said 'You don't hit men over forty' the moment had passed.

Practical inhibitions

The second category of inhibitions is practical; nothing to do with morality. Inhibitions in this category limit our behavior by reminding us of the dire consequences that might befall us if we don't observe them.

Exercise

Below, I have listed some of the examples we have talked about in this book, in the form of questions which invite you to say why the person in question doesn't just do the very thing that occurs to them. I have filled the first three in to show you the kind of thing that's in my mind.

- 1 Gerry is intensely irritated by his noisy neighbours playing their music over-loud next-door to him. What practical considerations stop him going around and giving his neighbours a real piece of his mind?

Answer: He believes that if he did that, they would probably play their music even louder. And in any case, the guy next door is bigger than Gerry so he feels he must treat him with some respect.

- 2 Colin is intensely irritated by his neighbours' kids playing football in the street outside and allowing their ball to run all over his garden. What stops him going around and giving the kids and their parents a good piece of his mind?

Answer: See above. In this case, too, Colin thinks the kids will probably just behave worse, and laugh and jeer at him every time they see him, and the parents might indeed encourage them to do that.

- 3 Pam is intensely irritated by the noise that her husband makes when he is eating. What stops her from jumping up, banging the table and shouting: 'For God's sake why can't you eat like a normal human being?'

Answer: She's afraid that if she did that it would bring to a head the whole disharmony in the marriage. He would realize that her irritation was not really with his eating, but with him in general; and that his noisy eating symbolizes something deeper, to her.

- 4 When a fifth man comes into a bar and leaves the door open, Steve is so angry that, when he gets up, he would like to punch the man straight in the face. What stops him doing this?

- 5 Judy takes her small daughter to the outpatient department and has to wait two hours before they are seen by the doctor and nurse. While she is waiting she finds that all the patients there (at least twenty of them) have been given the same (2 p.m.) appointment. What she would like to do is to really let rip at the doctor and nurse, who, by the way, were busy drinking tea together and not seeing their patients for at least a quarter of an hour. What stops her doing this?

- 6 Nigel is frequently irritated by his wife contradicting him while they are out in public. What he would like to do when, for example, she corrects him that the event he is humorously describing didn't take place on a Wednesday, as he says, but on a Tuesday, is, there and then, to give her a real piece of his mind, and shout at her: 'What the hell difference does it make whether it was a Wednesday or a Tuesday?' What prevents him from doing this?

- 7 Alan is frequently asked by his boss to do more work than he thinks he should be asked to. He would like to tell him where to get off, but doesn't, he simply goes home irritable. What stops Alan giving his boss a mouthful?

- 8 Chris, who drives a smart four-wheel drive, is annoyed by the bad driving of a character in an old wreck. Chris chases after him and, when the other car has to pause at the next roundabout, feels like driving straight up the back of him. What stops him doing this?

- 9 Ken is an executive who is so stressed out that when a customer asks him to do one more thing (which in fact is good business) he feels like telling him to get lost, or words to that effect. What prevents him from doing this?

- 10 Bob has not got much time for the police so, when he is stopped late one night and asked where he is going and what he is doing, he feels like telling the police officer to mind his own business. In truth, he feels like thumping him.

What stops Bob from doing this?

- 11 Tina has a thing about ‘bouncers’ at the entrance to clubs. So, when a bouncer stops her and her friend from going into a particular club, she screams and shouts at him and launches an apparently energetic attack – but one which, in reality, has no force in it. Why does she not launch a proper full-blooded attack on the bouncer?

Below are what seem to be the answers from the people in question. See how they match up with what you wrote.

- 4 When a fifth man comes into a bar and leaves the door open, Steve is so angry that, when he gets up, he would like to punch the man straight in the face. What stops him doing this?

Answer: He knows he would get banned from the bar, and his friends Ben and Chris probably wouldn't speak to him again either.

- 5 Judy takes her small daughter to the outpatient department and has to wait two hours before they are seen by the doctor and nurse. While she is waiting she finds that all the patients there (at least twenty of them) have been given the same (2 p.m.) appointment. What she would like to do is to really let rip at the doctor and nurse, who, by the way, were busy drinking tea together and not seeing their patients for at least a quarter of an hour. What stops her doing this?

Answer: Judy's main concern is to get the best possible treatment for her daughter. She doesn't want the doctor to be distracted by anything else, nor does she want him to 'take it out on them'.

- 6 Nigel is frequently irritated by his wife contradicting him while they are out in public. What he would like to do when, for example, she corrects him that the event he is humorously describing didn't take place on a Wednesday, as he says, but on a Tuesday, is, there and then, to give her a real piece of his mind, and shout at her: 'What the hell difference does it make whether it was a Wednesday or a Tuesday?' What prevents him from doing this?

Answer: The knowledge that that would be the end of the evening as far as everyone is concerned. In other words, a ghastly uneasy silence would descend upon everybody until someone made some feeble joke to try to break it.

- 7 Alan is frequently asked by his boss to do more work than he thinks he should be asked to. He would like to tell him where to get off, but doesn't, he simply goes home irritable. What stops Alan giving his boss a mouthful?

Answer: Alan is afraid that, after a few occasions like that, he might be heading for the sack, or, at best, pretty limited career prospects.

8 Chris, who drives a smart four-wheel drive, is annoyed by the bad driving of a character in an old wreck. Chris chases after him and, when the other car has to pause at the next roundabout, feels like driving straight up the back of him. What stops him doing this?

Answer: He knows that will probably cause a serious accident as a result of which he, Chris, will find himself in court; and the very least that will happen is that he will be banned from driving.

9 Ken is an executive who is so stressed out that when a customer asks him to do one more thing (which in fact is good business) he feels like telling him to get lost, or words to that effect. What prevents him from doing this?

Answer: He knows he would lose that customer, who would then go around bad-mouthing the firm, and gradually the firm would shrink and disappear.

10 Bob has not got much time for the police so, when he is stopped late one night and asked where he is going and what he is doing, he feels like telling the police officer to mind his own business. In truth, he feels like thumping him. What stops Bob from doing this?

Answer: He knows he'll probably end up being arrested and charged, and will lose out in some major way.

11 Tina has a thing about 'bouncers' at the entrance to clubs. So, when a bouncer stops her and her friend from going into a particular club, she screams and shouts at him and launches an apparently energetic attack – but one which, in reality, has no force in it. Why does she not launch a proper full-blooded attack on the bouncer?

Answer: She knows she would come off second best, and anyway doesn't want to do anything that could be seen as 'an assault'.

It's clear that these inhibitions have nothing at all to do with 'morality'. They are entirely to do with practical consequences and not wanting to lose out in some way. Entirely sensible, in fact.

So why do we get irritable and what do we do about it?

A perfectly reasonable question is: 'If there are so many moral and practical reasons for us to inhibit our irritability and anger, why do we ever feel that way? Humans aren't normally designed to feel and do things that have no purpose, so what's the purpose in this case?'

The main answer seems to be that it is a feedback mechanism – a way of letting other people know that what they are doing is going down badly with you. A way, therefore, of people becoming socialized and working together as a society rather than a collection of competing individuals.

In that case, why should we inhibit our inhibition and anger? If it fulfils this useful function of informing people when we feel they are they are 'out of order', presumably if we inhibit it then everything will go haywire. Other people will trample all over us, secure that there is no payback.

Well, if taken to extremes, that would be true. If you were never to show any

irritation, never to show any anger, this would probably be confusing for people. They wouldn't know when you were pleased and when you were displeased; it would be quite disorientating for those you mixed with.

But there is a happy medium. Some people we know are decidedly 'irritable'. We are not suggesting that they should *never* show any irritation or anger; that would probably be super-human (and, as we have just noted, not very helpful). There are things in life that *are* irritating, things which prompt a 'normal' person to show some irritation. When we describe a person as 'irritable', however, s/he is going too far, becoming irritated by things that wouldn't irritate a 'normal' person, or getting more irritated than most by slightly irritating things.

So, as ever, it is not a question of 'all or nothing'. Yes, it is sometimes just as well for people to be able to sense that we are irritated or angry. On the other hand, it is very easy to take this much too far, to the point where even the slightest thing irritates us, or where we become irritated if things are not *exactly* as we want them. In that case our irritation and anger mechanism is clearly over-functioning, to the extent that it is counter-productive. When it is functioning at just the right level it provides useful feedback to other people; they can sense when we are slightly irritated and angry with what they are doing and as a result will probably desist. If it is functioning in too extreme a way, those around us get frightened and worried, and our relationships begin to break down.

A good parallel is with jealousy and possessiveness. Most people rather like their loved ones to exhibit a small amount of jealousy and possessiveness towards them. If this is not the case, many people take it as an indication that they are not really loved. So, a small amount of jealousy and possessiveness is perfectly fine, even a good thing. But what happens when this is taken too far? When someone spends all their waking moments worried about what their loved one is doing, whether they are being faithful and loyal? Some people go to the extent of popping home unexpectedly, leaving listening devices around the house or on the phone, even hiring private detectives to follow their loved ones around. Clearly, this level of jealousy and possessiveness is counterproductive and is very quickly going to lead to a breakdown in the relationship.

So, in both instances, whether we are talking about irritability and anger or jealousy and possessiveness, you can have too much of a good thing. In fact, rather like a homoeopathic medicine, the right amount is very little indeed!

Putting the brakes on

We can see, then, that for all sorts of moral and practical reasons we want to limit our irritability and anger very severely – almost to the extent of stopping it before it gets going. If we keep it down to very low levels it can work extremely well for us and for everybody around us; if we let it get any higher the reverse is the case: it works really badly for us and all around us.

So how do we perform this difficult balancing act, of keeping any irritation and anger down to useful and beneficial levels – down to those very subtle levels where those around us actually feel pleased to see the very occasional irritation from us, simply because it gives them feedback about what is happening?

For a task as complex as this we need a simple analogy. The best I know is that of traffic lights. If you drive around any reasonably large town you will find there is a

complex system of interacting traffic lights. For example, near where I live there is a ring road round which I have to drive to get to the motorway. At one point on this ring road there is a particularly distinctive sequence of lights. The first set normally brings you to a halt; for some reason they usually seem to be on red. While you sit waiting at these lights, you can also see that the second set of lights you have to go through is also on red. In due course your first set turns to green, and you move off. If you go off at a very moderate pace, by the time you reach the second set (which is only 40 or 50 metres away) those too are changing to green and you can sail across, although you do have to keep your wits thoroughly about you during this procedure. The same applies to a third set of lights, again only 40 to 50 metres ahead; these too are in sequence with the first and second sets, and you can time things to get across all three in one steady passage.

In summary, what would be a completely unruly flow of traffic is first of all brought to a halt, then allowed to proceed in a thoroughly orderly and controlled fashion. Of course, there are other roads crossing the road I am on, hence the need for lights. An aerial view of this whole procedure would reveal an amazing number of vehicles, all meshing superbly and proceeding at as reasonable a pace as they possibly can. A real feat of interaction and coordination.

Exactly the same happens when two or more people are interacting with each other. Each individual has their own senses of direction, their own pace they want to keep up, their own interests. At the same time they are very keen to mesh with one another, not only because they know that is to their mutual advantage, but also because it's enjoyable and satisfying.

So how does the traffic lights analogy work in practice? Remarkably simply. All we have to do is learn to spot a red light! And that's easy. Any amount of irritation or anger we feel is, effectively, a red light. So we don't just barge across it; that way lies disaster.

When confronted with a red light, irritation and anger in other words, we stop. This is not a 'give way' sign; it is very definitely a 'stop' one. We really have to make sure we come to a complete halt. Sometimes people say 'count to ten'. Well, you can do this if you want; certainly it brings things to a pretty marked stop. On the other hand, you can simply note the presence of the 'red light' (irritability and anger), carry on talking about whatever you like, and then, when the irritability and anger have subsided to a tiny amount (the lights change) you can get ready to move on to say whatever you think is best.

How does that work in practice? Here are some real examples, the first of which – you will not be surprised to learn – concerns Steve, in a draft at the bar.

1 Steve at the bar

Red light: Yet another man comes in, leaving the door open. Steve experiences a sudden surge of anger, which he recognizes as a red light.

Wait: Quickly, almost instantly, Steve's anger drops to a very low level. Simply refraining from speaking for a moment has helped. He judges the best thing to say.

Green light: Steve leans over towards the man who has just come in and is about to walk past, and says: 'Push the door to, would you, friend, it leaves a heck of a draft.'

And, moreover, he can repeat this sequence time and again, just as he can manage hundreds of traffic lights on a journey.

2 Ian dropping mug on floor, irritates Sue

Red light: The sound of the mug smashing on the floor produces a sudden surge in adrenaline in Sue, which she recognizes as the red light. She says nothing for an instant, while the anger quickly drops to a more minor level.

Wait: With her anger at a much lower level, she works out the best response.

Green light: Still with a trace of irritation in her voice, she says: 'Get a brush and sweep that up and put it in the bin, there's a good boy.'

Again, this is an interesting one, because it is not just mugs that Ian breaks; in truth, he is somewhat careless. It is therefore probably appropriate that Sue's voice has just a dash of irritation in it. It's certainly very genuine, she really feels the irritation. But by thinking in terms of the traffic lights procedure she puts it into a useful context rather than a destructive one.

3 Vicky tells of Danny and her underwear

Red light: Danny felt intensely angry that Vicky had broken a very intimate confidence, not just to a few other people, but on the radio. This intense anger persisted for several days. He therefore said nothing.

Wait: When the anger subsided to a more manageable level, Danny worked out the best way to approach the subject.

Green light: At a moment when there was plenty of time, and he and Vicky were getting on reasonably well, he said: 'I'll tell you something I think we should talk about, because you know I was really angry about what you said on the radio the other day. It seems to me we should talk about what needs to be kept between the two of us and what can be said to others, because I know both of us come under pressure from smart interviewers to say things we'd rather not say. So I guess we ought to get our act together now about how we're going to cope with that.'

4 Anne finds her daughter in the bath rather than tidying her bedroom

Red light: Anne, having thought that her daughter was at last tidying her room, goes up and finds that is not the case. Gradually she realizes that, in fact, the girl is in the bath. Feeling furious, she refrains from doing anything for a little while.

Wait: Anne's initial burst of outrage has now subsided to a lower and perhaps useful level of irritation. She works out the best way to move forward.

Green light: Helen decides to wait until her daughter is out of the bath and dressed again. Then she goes to her room and says, with the tiniest hint of irritation, a large dash of determination, and also a smidgen of friendliness: 'Look, dear, we're really going to have to get this room of yours tidied. So come on, I'll help you with it.'

The traffic lights technique is a remarkably strong and powerful one. But there are several points to be made. Sometimes the 'red light' stays on for a very short period of time, barely a second or two. Steve in the bar, and Sue with Ian who drops the mug on the floor, are examples of this. In other cases the red light stays on for hours or even days – as with Danny and Vicky.

Secondly, you don't always get what you want. Anne is an example of this. She never got to the point where her daughter set about happily tidying her bedroom all on her own. And we have to recognize that there's no law that says we should get

what we want, any more than other people always get what they want. There's no need to 'awfulize' this phenomenon. It's just the way things are.

The third point, and the best news, is that just as we get good at coping with real traffic lights, we also get good at coping with these metaphorical ones. So, whereas previously Steve became more and more incensed every time somebody left the door to the bar open, he now became more and more skilled at going through the traffic lights procedure. So each time he said 'Push the door to, would you, friend, it leaves a heck of a draft,' it seemed like the first time he had said it as far as the hearer was concerned; but in fact, this was now a skilled procedure he had developed.

Likewise, and perhaps in particular, for Sue with Ian the mug-breaker. Ian gave Sue plenty of practice in spotting red lights, but Sue did her bit by recognizing them and moving through them efficiently and productively.

EXERCISE

- Think of a 'red light' that has occurred over the last two days: something that actually made you angry, or potentially could have done.
- Did you recognize it as any sort of a red light and stop at that point?
- Did you stop and wait for the anger to subside to a very small amount and then decide on your best way forward? Did you then move off along the productive path you've chosen?

Well, unless you've read this book before, presumably you've answered no to one or more of those questions. So here is another ...

EXERCISE

- Again, what exactly was the 'red light'? In other words, what happened to make you angry?
- What would 'stopping' have meant in that situation? In other words, could you simply have said nothing, or would that have looked strange? Would you perhaps have had to carry on talking in some way or carry on doing what you were doing? In that case the 'red light' is simply not responding to your anger but instead carrying on with what you were doing.
- When your anger has subsided to a low level, what would have been the best path to take? This is the amber phase: your anger is at a low level, and *you* (not your anger) are deciding on the best way forward.
- What exactly would 'green' have looked like? In other words, what would you have said or done? What tone of voice would you have used?

If this all sounds very complicated, that's misleading. It is a very simple and very enjoyable procedure. It is best, however, to go through it in your mind a few times, just as the second of these two exercises suggests. Each time you hit 'red', recognize it as such, allow the anger to subside to a very low level, and then decide on your best way forward. Then move forward, actually do what you've decided on (green).

TIP

There is only one trap in this procedure, and that is to kid yourself that you're at amber when in fact you're still on red. Remember, the characteristic of being at amber is that your irritation and anger are at *very low levels*. Sometimes, it is true, this may be just half a second after the intense initial burst of anger. At other times, however, it is a good while afterwards.

SUMMARY

In this chapter we have looked at:

- The types of inhibitions that exist: *moral* inhibitions based either on 'What would happen if everybody did this?' or on 'clear rules', and *practical* inhibitions, which are based simply on the practical consideration of what would happen either for you or for other people if you acted on your raw anger.
- Why we get irritable and angry: the idea that a very low level of irritability and anger provides useful

feedback to those around us, while anything above this very low level is counterproductive and simply puts everybody on edge.

- How we can bring inhibitions to mind when we want them, and act on them usefully by using the traffic lights procedure.

PROJECT

Three projects come out of this chapter:

- 1 Read through all the material on inhibitions and get it really clear in your mind what your inhibitions are. Remember, these inhibitions are going to prove really useful to you. They're the 'motivators' for you to keep your irritability and anger down to a very, very low level. Write them down.
- 2 The practical project is the traffic lights one. Really practice spotting 'red lights'. In other words, practice spotting when you become angry. Allow it to sink to a low level (amber) as quickly as possible. *Only at that point* do you decide what would be a reasonable way forward. Then, when you've decided, move on to green; in other words, put into practice what you think is the best way forward. And remember, just like Anne, you can't always have your own way!
- 3 As ever, review your successes, either mentally or on paper.

The bottom line: Response

You know what they mean by ‘the bottom line’? It comes from business and refers to the bottom line of the accounts: the final profit (or loss) figure. It doesn’t matter whether the head of the business has been extremely hard-working and everyone else in the firm incredibly conscientious, if the bottom line is that the business made a loss then that, in a sense, is all that matters. Conversely, it doesn’t matter that another business might have a lazy and lethargic head and an opportunistic workforce; if the bottom line is that they are making a healthy profit, then that, in a sense, is all that matters.

It’s the same here. In our model (Figure 14.1) we are now looking at the ‘response’ box. The point is that if our final response is an acceptable one (i.e. non-irritable, non-angry) then it really doesn’t matter what our beliefs are, what our mood is, what triggered things off, how angry we got, how good we are at implementing inhibitions, and so on. In theory at any rate, you can have everything piling up against you and still make an acceptable response. And in fact it’s not just theory, it can really happen in practice too.

So, if you are looking for a short cut, this is it. Personally, I wouldn’t use it as a short cut, because if you *do* use it like that it is a route strewn with difficulties. If I were you I’d regard it as the final piece of the jigsaw; that way you have everything pulling on your side.

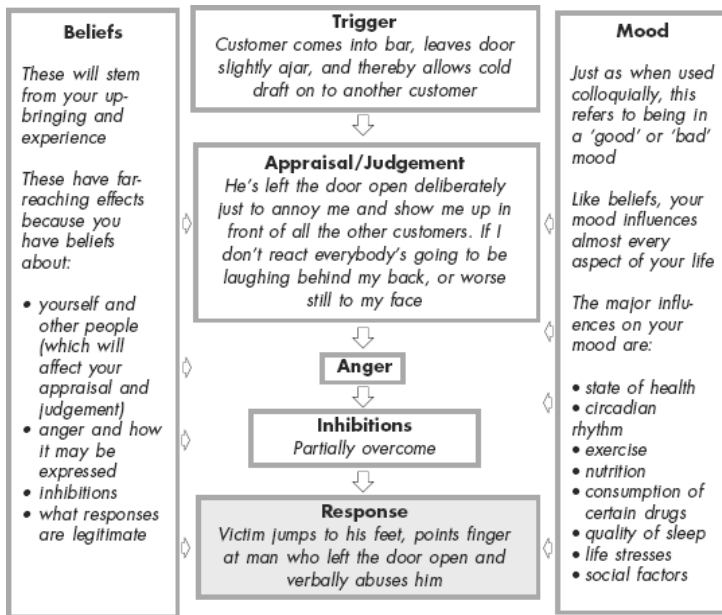


Figure 14.1 A model for analyzing irritability and anger

Either way, as far as anybody else is concerned all they can see is your response. It doesn't matter to them what's been going on inside your head; if you respond irritably and angrily then, as far as they're concerned, you are an irritable and angry person. Equally, if you respond in a non-irritable way and a non-angry way, then that is how they see you.

So, given that most of us would prefer *not* to be seen as irritable and angry, what do we do? The good news here is that we have covered most of what we need to cover already. The three key concepts are:

- the traffic lights analogy;
- modelling yourself on a good example;
- reviewing successful (and unsuccessful) incidents.

Traffic lights

Let's go through the traffic lights analogy first.

The 'red light' comes on when you can see that you are about to make an irritable and angry response – or at least, a response that will be seen by other people as irritable or angry. You treat this impulse as a red light: in other words, you literally stop. All you do is *not* say or do whatever it is you were going to say or do. If other, similar, things come into your mind, then you stay at the stop light. You get ready to move off *only* when you start thinking of alternative, non-irritable, non-angry responses.

Sometimes you can only think of one 'reasonable' response. Sometimes it takes a

long time for such a response to occur to you. In that case, it simply means you are stuck on red for a long time. This is, of course, entirely true to life; just occasionally you come across lights which seem to be stuck on red for ever. But eventually, sometimes after half a second, sometimes after half a week, you think of a reasonable response. That is your cue to move on to green.

The ‘green light’ is simply doing whatever the reasonable response is. But remember, ‘reasonable’ is in *your* judgement, not the judgement of your anger. You know full well that your anger tells you to do things that the genuine *you* would disagree with. So, don’t let your anger have the last word; insist that *you* do.

One of the examples we used earlier was Sue coping with her careless son Ian, who’s prone to drop things and break them – mugs, for example. She describes one instance where, as soon as the mug smashed on the floor, she felt an overwhelming surge of anger; she just wanted to shout anything at him. She also describes recognizing that as a red light, and simply keeping her mouth shut for a moment. This was, more or less, a ‘half-second’ red light. No sooner had she come screeching to a halt on red than she quickly saw that all she needed to do was to get him to sweep it up. In other words, she moved straight on to amber, where a reasonable response occurred to her; and then on to green: ‘Just sweep it up, there’s a good boy,’ said with the merest hint of annoyance.

The same with Chris, the character who was prone to road rage. He trained himself to recognize the red light too. He described an instance where somebody pulled in front of him rather more sharply than he felt they should have done; having braked, he literally felt his foot having a will of its own, wanting to get on to the accelerator to ‘tailgate’ the offender. He had by this stage of training learnt to recognize this impulse and he simply refrained from giving in to it. The ‘right response’ for Chris was telling himself to ‘drive by his own standards’. The green light was simply doing that: taking his instruction literally, driving well and responsibly.

Following a good example

The second concept is that of modelling yourself on a good example. I have to tell you that this also is one of my very favourites. The great thing about having an example to model yourself on is that you can clearly envisage what responses you can make. All you have to do is to ask yourself: ‘What would he or she do in this situation?’ and you have a ready-made template for your own behavior. Then it’s just a case of mimicking it.

So, by spending a couple of minutes now, you can save yourself endless hours of difficulty later on. All you need to do in that brief time is to think of somebody who would make a really good example for you. Here are a few tips to help you choose:

- You are looking for somebody, preferably the same gender as you but not necessarily, who typically makes non-irritable and non-angry responses. Someone who is difficult to get angry. Do *not* model yourself on somebody who easily becomes irritable and angry!
- It should be a person who you like, even admire; someone you would be pleased to be thought similar to.
- The individual you’re modelling yourself on does not have to be ‘perfect’. They may have elements to them that you would not want to copy. Even so, by and large, you like or admire them and, certainly, they are non-irritable and non-angry.
- The person you bring to mind may be someone you know from real life, or someone you know

only in a public role, perhaps from television or radio. It is important, however, that you have a very vivid idea of what they say and do, so that you can copy it easily.

You might find more than one person to model yourself on. This is not necessarily a good thing, because in the heat of the moment you need to have one clear image to copy. So you're probably best off, certainly in the initial stages, having just one person to bring instantly to mind, so that you can quickly ask yourself what he or she would do in this situation.

Hence Graham (the one whose wife, Fiona, irritated him by flirting with other men) used Ian as a model. (Ian's wife, Hannah, was also something of a flirt, but only in the same harmless way as Fiona.) This was a highly appropriate model for Graham because he knew both Ian and Hannah well, recognized that Hannah had many similarities to Fiona, and could see that if only he brought himself to behave just like Ian did, then all would be well. In fact this worked out especially well because it meant that the four of them got on better than before, with each of the quartet involved effectively in 'mirroring' one another.

Paul, the father of the twelve-year-old boy who hadn't done his homework, used the character of a middle-aged teacher from a television soap opera as his model. This was an interesting one; I wasn't convinced this was a very good role-model to choose, first because this character was rather older than Paul and second because he was in fact a teacher and was therefore in a position to help youngsters with homework quite readily. Paul wasn't particularly good at his son's homework himself, so wasn't that good at helping. The third thing that slightly worried me was that this character was a bit 'too good to be true', so I was worried that Paul might be setting himself an impossible target. Happily I was proved wrong, and Paul found his role model a very good one. Even when he couldn't help his son, John, it still seemed to carry him through. Such is the power of 'modelling'.

Reviewing

You will recognize that this idea comes up time and again. Quite rightly too; it is very important indeed. This is how we really consolidate things: by reviewing both good and bad events, and taking our lessons from them.

So, if you do let yourself down at all (i.e. get too irritable and too angry) then, as soon as you have got back to your normal self, do a thorough review. What would you have preferred to do in that situation? (In other words, what response would you have preferred to make?) Would it have been best to use the traffic lights technique, the modelling technique, or to combine the two? When you combine the two you simply stop at the red light of irritability and anger, think of your role-model to help you come up with a suitable response (the amber light), and then move off to mimic that response (the green light).

So you literally relive the situation, but give it a better ending. This, technically, is known as 'cognitive rehearsal'. It is very effective because, as mentioned before, the brain can't really tell whether you're doing things in reality or in imagination. So you are treading the path through the jungle, preparing a path so that the next time a similar situation arises you're more likely to respond in the way you want to rather than in the way your habit or your anger tells you.

A NOTE OF CAUTION

There is one trap in reviewing and that is that you simply relive whatever it is that made you angry. Be careful to walk around this trap. The whole point of reviewing is to relive a *better response*. Certainly people do and say things which we would prefer they didn't do and say, but that does not mean we have to respond badly. So, we relive and practise (mentally) *the response we'd prefer to make*.

Just as important, possibly even more so, is to relive our successes. When we see something happen that would formerly have produced a really bad response from us, and yet, this time, we handle it well, then we must take time to indulge in self-congratulation. As soon as possible after the event, do a review in just the same way as if you had *not* responded as you would have wished. Again, take care to walk round the trap of simply reviewing what might have made you angry. Rather, review how you managed to respond so well as you did. You can even take it a step further and imagine various other triggers and how you would respond to them in a non-irritable, non-angry way.

SUMMARY

- In this chapter we have seen that we could, if we wished, cut through everything else to the 'bottom line': how we respond. No matter what triggers are put in our way, we are responsible for our own responses.
- There are three good ways for you to get yourself to produce the kind of responses you want to, and those three ways mesh with each other.
- First is the traffic lights technique. When you feel a surge of irritability and anger you simply stop. And you stay on 'red' until you can think of a reasonable response (from *you* rather than your anger); this is 'amber'. Once you've got that response clearly in mind you can move on to 'green' and implement it.
- Second is the technique of modelling yourself on a good example. You think of a particular person who always (so far as you know) responds well in adversity, in other words in a non-irritable, non-angry way. You hold this person in mind constantly and, when you are confronted with potential irritability- and anger-producing situations, you respond as s/he would do. Eventually this becomes part of you: you will have grafted these better responses on to the good elements of your own personality.
- Third is the technique of reviewing: instances where you responded badly and – especially – those where you responded well. In both cases you rehearse future responses where you literally envisage the potentially anger-producing stimulus (but avoid the trap of getting involved in reliving it) and rehearse the response you would prefer to make.

PROJECT

The best project from this chapter is to implement all three of the methods we have been talking about.

- Start with the traffic lights technique. Become razor-sharp at recognizing impending irritability and anger, and put yourself on red straight away. Think of the person you have set as an example to model yourself on, and what s/he would do in this situation. This puts you on to amber, because you now have a picture of a really good (non-irritable, non-angry) response. Then move on to green, in other words implement that response convincingly and with enthusiasm.
- That meshes the first two techniques. All you then need to do is to review the times you successfully implement them – and, indeed, review the times when you fail to implement them and how it should have gone. Both of these are good things to do.

This is a very solid project which will be of tremendous benefit to you if you put your heart into it.

‘But I’m not always irritable, just sometimes’: Mood

Do you ever have that experience where you just *feel* irritable? No one has even done anything yet, but you know that if they did then it would really irritate you. Or you are with other people and absolutely everything anybody says or does, and the way they do it, irritates you.

Perhaps other people don’t realize you’re feeling that way, perhaps you’re able to keep it to yourself – possibly as a result of reading the previous chapter on ‘responses’. But inside you’re just feeling tremendously ‘prickly’.

Colloquially, this is referred to as ‘being in a bad mood’, and this about sums it up. Technically, too, that feeling comes under the heading of ‘mood’. Back in Part One (Chapter 7) we looked at the kind of things that influence mood, namely: routine, exercise, nutrition, drugs, sleep, illness, stress and social factors. If we can get these factors right, then we are much less likely to find ourselves in ‘a bad mood’ (see Figure 15.1).

Interestingly, many people have got so many of these factors awry that they spend a good deal of their lives in a bad mood, and indeed feel that this is ‘part of life’. The good news is that this is not so; it’s perfectly possible – and reasonably easy – to sort out these factors so that recurrent ‘bad moods’ become past history.

So, let’s take them in turn.

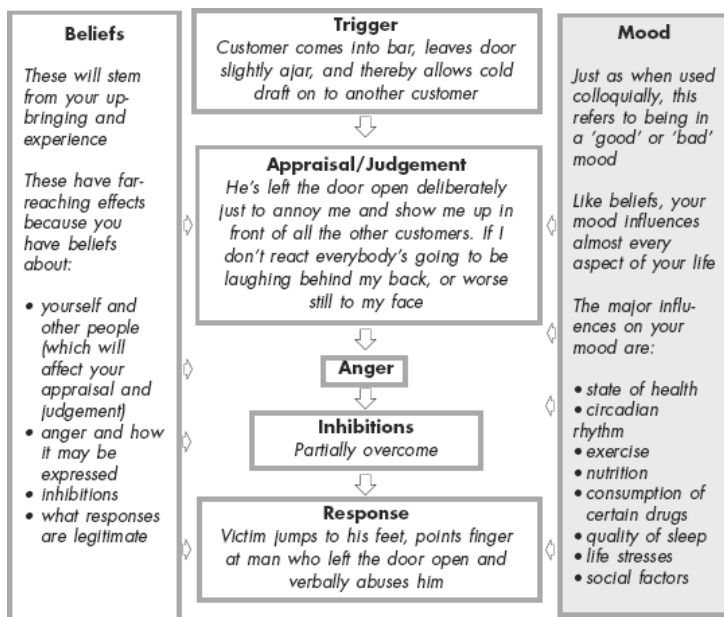


Figure 15.1 A model for analyzing irritability and anger

Routine

The body loves routine, doing the same things at the same time most days. Don't be tricked by the idea that 'routine' need be boring. On the contrary, you can if you wish lead the most exciting life of anybody in the world; just make sure you do it every day!

The two *main* things that the body wants to do at regular times are eating and sleeping. Of the two, sleeping is probably the more important.

So what you need to do is to go to bed and get up at roughly the same time most days.

Likewise, you need to try to eat at roughly the same times most days. The best way of doing this is to set yourself times for breakfast, lunch, tea and supper (if those are the meals you eat), and then give yourself half an hour's leeway either way. So, you might say that you eat breakfast at 8 a.m., lunch at 1 p.m., tea or snack at 5 p.m. and supper at 8 p.m., which would in fact mean that you had breakfast some time between 7.30 a.m. and 8.30 a.m., lunch at some time between 12.30 p.m. and 1.30 p.m., tea or a snack at some time between 4.30 p.m. and 5.30 p.m., and supper at some time between 7.30 p.m. and 8.30 p.m.

I labour the point because I have seen some people who become over-meticulous about eating at *exactly* the same time every day, and that can be constricting and difficult to maintain. All I am suggesting is that you eat and sleep at *roughly* the same times, most days.

And what happens if you don't? If you know what jet-lag is like, then that's what your life becomes, except that you are permanently in a state akin to jet-lag. There is

nothing mystical about how jet-lag occurs: it has nothing to do with jet engines or aeroplanes in themselves, it is simply that one moves from one time zone to another, and this upsets the ‘body clock’, one’s physical rhythm or routine. Technically, this is known as the ‘circadian rhythm’ – the rhythm of regularity around a 24-hour cycle that the body likes to maintain.

And when you’re in a state of jet-lag – which is often characterized as ‘tired and irritable’ – you are, sure enough, irritable. So, just by ensuring that you maintain a regular routine you may well massively reduce your irritability.

CIRCADIAN RHYTHM PROJECT

This all leads to a very clear and powerful project.

Step 1: List all of the following:

- Get-up time:
- First meal time:
- Second meal time:
- Third meal time:
- Fourth meal time (if any):
- Bedtime:

Step 2: Stick to the times you have written, within 30 minutes either way.

Step 3: You can make a diary of this if you want; in other words, simply record the actual times you eat and sleep. You might be surprised how difficult it is to keep them regular, especially if you’re not in the habit of doing so. However, persist; this is one of the linchpins in producing a stable mood for yourself.

Taking exercise

Yes, I know you’ve heard it before, that exercise is very good for you. Well, I’m afraid it’s entirely true: human beings are indeed designed to take exercise. It lifts the mood, strengthens up all manner of physical factors, and is generally absolute magic.

The only good news (if you are anything like me) is that exercise does not have to be strenuous. You do not necessarily have to go to a gym and ‘work out’. Walking is just as effective.

Conventional wisdom says that aerobic exercise is best, but more recent research seems to suggest that any exercise is good exercise. So, walk whenever you can, run upstairs – generally just get as much exercise as you possibly can fit in. If you want to go swimming as well, or join a gym, then of course this is excellent too. But don’t do any strenuous exercise without checking things out with your doctor.

A COUPLE OF TIPS

Three factors that have cropped up fairly regularly with people I have seen are as follows:

- People (especially, but not only, women) say that they would walk but they are inhibited from doing so by the wrong shoes. We are not talking about ‘serious’ walking; just walking to and from the bus stop, or even upstairs sometimes. Clearly there is a question of how much priority is being given to exercising here; give it a bit more priority and make sure you have shoes that are comfortable enough to walk in and, if you like, even look good as well.
- Some people, whose natural opportunities for exercise are virtually nil, say that when they get home they are too tired to exercise. The first point to make here is that if they could make themselves exercise, then the exercise itself would make them feel more energetic. The second way of looking at it (because it is in fact very difficult to ‘make’ yourself exercise) is again that they should give the exercise more priority: in other words, exercise earlier in the morning, at midday, or at some other time, if they know that they are going to be too tired in the evening. (And, in turn, this would make them feel less tired in the evening too.)
- Some people are tempted to mix exercise with anxiety. For example, I had one chap who deliberately set off slightly late to catch the bus every morning. This meant that he would have to walk fairly briskly down

the road to the bus stop. This is a pity; exercise is meant to be an entirely natural and anxiety-free activity!

EXERCISE PROJECT

This too is a key area with massive potential benefits for you.

- The best project is simply to keep a diary of how much exercise you get. This can be 'endemic' exercise, where exercises are simply 'built into your routine' by way of walking from one place to another and so forth. In fact, to make it part and parcel of your routine is probably a very good idea; this means it won't slip once your enthusiasm wanes! Or it can be 'scheduled' exercise: deliberately going for a walk, or for a swim, or for a session in the gym.
- Either way, it is a very good idea to record how much exercise you're getting. Take it from me, it can be very salutary indeed to see just how little one sometimes gets!
- The final question is: just how much exercise *should* you get? The answer is: pretty well as much as you like. For those of us in a 'normal' routine it is very difficult to get too much exercise. Just make sure you get plenty of non-strenuous activity. To be breathing faster than normal and possibly even sweating is a good thing; to be noticeably breathless and in discomfort is not.

Nutrition

In most of the western world people certainly consume plenty of calories. But whether you get a diet that is good for you is perhaps another matter.

There often seems to be a lot of conflicting information around about what constitutes a good diet, and that sometimes means that people feel like giving up and eating whatever they feel like eating. That is a pity, because it is simple enough to get a reasonably balanced diet.

Current conventional wisdom is best summarized by saying there are four main types of foods –

- 1 fruit and vegetables;
- 2 foods such as bread, rice, potatoes;
- 3 high-protein foods such as meat, fish;
- 4 high-fat foods such as biscuits, chocolates, etc.

– and that we should eat them in that order of quantity. There is nothing 'wrong' with any of the four categories; it's simply a matter of proportion. We should eat most of the fruit and vegetable category, least of the high-fat foods, with the others in between.

Incidentally, it is probably a mistake to actively avoid particular types of food unless you have a clearly diagnosed allergy to them – as in the case, for some people, of nuts. For instance, it can be unwise to actively avoid cholesterol, because excessively low levels of cholesterol have been shown to be associated with low mood. (But, equally, taking a moderate amount of cholesterol does *not* necessarily mean eating a lot of biscuits and chocolates; some of the best forms of cholesterol occur in oily fish such as mackerel, herring, etc.)

The next thing is: how good are you at digesting your food? No doubt you were told it as a youngster that you need to chew your food properly before swallowing – and it's still true! The reason for this is not only that digestive juices are secreted in the mouth, but that chewing also stimulates the production of other juices in the digestive tract, so that, when the food arrives there, it is 'expected'.

Similarly, it is best if you can 'put your mind to' eating, rather than eating while you are on the move, talking in too involved a way with other people, and so forth.

And finally, it is still true that most people don't drink nearly enough water. And it *is* probably best to say 'water' rather than 'fluids', even though the latter sounds so much more technical! The trouble is that if you think in terms of 'fluids' it opens the door to too much coffee, tea, etc. Best to think in terms of water. You don't have to drink any more than you want, but do drink plenty.

NUTRITION PROJECT

There's no need to go overboard on this one. Just ensure the following:

- Eat an approximately balanced diet, as described above.
- Give your body a good chance at properly digesting the food you eat by having some respect for mealtimes, food and your digestive tract! Remember, it is not so much the case that 'we are what we eat' as 'we are what we properly digest.'
- Drink plenty of water.

I say 'there's no need to go overboard' simply because I wouldn't want you to get obsessed with what you eat, how you eat it and what you drink with it. Nevertheless, nutrition is important; so, if it's especially relevant to you, make sure you sort it out.

Drugs

In this section I just want to talk about the so-called 'endemic' drugs: caffeine and alcohol. They are termed 'endemic' because they are part and parcel of everyday life as far as many people are concerned.

Caffeine is probably the bigger offender as far as disrupting mood is concerned – and a worse offender than most people think.

First of all, let's have a look where it comes from. Table 15.1 below shows us that the major sources of caffeine are coffee (including instant), tea (more or less on a par with instant coffee, which surprises many people), and cola drinks. There is also a fair amount in dark chocolate, especially if you eat lots of it!

TABLE 15.1: THE CAFFEINE CONTENT OF SOME DRINKS AND FOODS:

Item	Average caffeine content (mg)
Coffee (5 oz cup)	
brewed drip method	115
brewed percolator	80
instant	65
decaffeinated, brewed	3
decaffeinated, instant	2
Tea	
brewed (5 oz cup)	50
instant (5 oz cup)	30
iced (12 oz glass)	70
Cocoa beverage (5 oz cup)	4
Chocolate milk beverage (8 oz)	5
Milk chocolate (1 oz)	6
Dark chocolate, semi-sweet (1 oz)	20
Coca-Cola (12 oz)	45.6
Diet Coke	45.6
Pepsi Cola	38.4
Diet Pepsi	36
Pepsi Light	36

Some weight-control aids, alertness tablets and diuretics also contain significant amounts of caffeine.

Source: US Food and Drugs Administration.

Both caffeine and alcohol are listed as substances which produce substance-related mood disorders in the American Psychiatric Association's *Diagnostic and Statistical Manual* (4th edition, 1994). It comes as a surprise to many people that caffeine can have the far-reaching effects it does. It has been shown to be associated with low birthweight for babies from high caffeine-consuming mothers and an increased risk of cardiac problems in high caffeine-consuming people; and of course it is known for its sleep-disturbance properties and the 'jittery' effect that many people have when they drink too much.

In summary, caffeine is one of those substances that is best taken strictly in moderation. There is some evidence that at such a level (around three cups of instant coffee per day) it has quite a good anti-depressant effect; much more and you really need to be cutting down, back to around that daily level of three cups.

If you are drinking an excessive amount of coffee (and I've come across people who drink thirty cups a day), the best way of cutting down is first of all to halve your current consumption. Then hold that level steady for a week or two. Then halve it again. Then hold that level for a week or two, and halve it again if necessary – keeping going until you get to around three cups a day.

You may well find it surprisingly difficult to cut back because, although most people don't think they are addicted to the amount of caffeine they consume, you probably are. Common withdrawal symptoms include painful headaches and tiredness, although in total it appears that caffeine depletes your energy levels rather than boosts them. Some people who have headaches first thing in the morning or at weekends find that they are associated with caffeine withdrawal because, naturally enough, one doesn't normally consume caffeine through the night and many people drink a lot more caffeine during the working week than at weekends.

In summary, then, limit yourself to around three cups of instant coffee or its equivalent each day. And even then, don't have one of those in the evening time or it will probably interfere with your sleep.

Pretty much the same applies to alcohol. In moderation it's fine, but in excess it really is troublesome.

Recommended weekly maxima in the UK are currently 21 units for men and 14 units for women, where a unit is roughly equivalent to a glass of wine, half a pint of beer or a measure of spirits. Current US recommendations are for a slightly lower intake; the Connecticut Clearinghouse ('a program of Wheeler Clinic Inc., funded by the Department of Mental Health and Addictions Service') says that 'moderate drinking' should not be exceeded, and defines 'moderate' intake as one drink a day for females and two drinks a day for males, where one drink is equivalent to 1.5 ounces of distilled spirit (80% proof), 5 ounces of wine or 12 ounces of regular beer.

Personally, although I confess to being rather fond of drinking, I expect that the UK maxima will be lowered in due course. Anyway, if you drink much more than this and also find yourself troubled by irritability, then you really need to work hard at getting down to these limits as a maximum.

The real problem with alcohol is that it interferes with your sleep. Contrary to popular belief, the chances are that your quality of sleep is actually impaired rather than improved by consuming alcohol. Obviously, taken in large amounts it leaves you hung over, and taken even in not very great amounts it still leaves you under par the next day, partly because it attacks your supply of B vitamins.

It's no real answer, but if you are drinking too much alcohol and find it very difficult to cut it down to reasonable levels, then at least make sure that you take regular multivitamin supplements. Clearly this is not half as good as not damaging yourself in the first place, but it does go some way to undoing part of the damage.

ALCOHOL PROJECT

- This one is clear and simple: get down to the recommended maxima of alcohol per week.
- Obviously this is a very important one, not only because of the implications for your irritability, but also in terms of minimizing the damage alcohol does to your liver and brain especially.
- If you can manage this by yourself, simply by starting up a new habit of drinking a lot less, then so much to the good. If you need some outside help, it's worth getting it. Your family doctor might be able to recommend somebody, or you can get in touch with Alcoholics Anonymous (local contact numbers are in the phone book); you don't have to be drinking as much as you think in order to get help from them.

Recreational ('street') drugs

This category covers a great many drugs, and I am not expert on any of them, so I don't propose to say too much here. I would rather leave it to your own judgement. Given what we have said above about the 'routine' drugs of caffeine and alcohol and the damaging effects that they have been proved to inflict upon us, you can probably judge for yourself what effect other drugs might be having on you, if you are taking any, and what you had best do about it!

Sleep

The importance of sleep is very difficult to overstate. If you can get into the routine of having a good night's sleep, then this will have a major impact on the quality of your mood. There are a number of rules, many of which have been mentioned already:

- Get up at a regular time; the body likes routine.
- Eat at regular times; again, the body likes routine.
- Avoid too much caffeine (not more than around three cups of instant coffee per day) and too much alcohol (not more than three units per day if you are a man, two if you're a woman).
- Get a reasonable amount of physical and mental activity into your day; try to break the vicious circle of feeling tired, therefore not doing much, therefore not sleeping very well and therefore feeling tired . . .
- Have a wind-down period before you go to bed; a low-activity routine so that you go to bed relaxed.
- Make sure you're neither too hungry nor too full when you go to bed.
- Ensure that you have a regular bedtime; again, the body likes routine.
- Some people find they are able to induce a state of happiness as they lie in bed; if you can do this it's a good idea – happy people sleep better than unhappy ones!
- Make sure you've got rid of any extraneous sudden noises from central heating or anything else, and that you are warm enough but not too hot.

Well, that isn't exactly a fully comprehensive account of how to reform your sleeping habits, but it's a fair start. If you really make sure that you are doing all of those, all at once, then you shouldn't be sleeping too badly at all. Only one other thing; don't *try* to sleep – even if you just lie there awake but relaxed all night your brain will go into a different mode and you'll have a reasonable amount of rest, so long as you don't actually harass yourself with trying to sleep.

SLEEP PROJECT

- Regardless of whether you think of yourself as having sleep problems it is still an excellent idea to get as good a night's sleep as possible. The importance of a good night's sleep is very difficult to overestimate.
- Therefore apply your mind to implementing as many of the above points as you can, including setting realistic times for bedtime and getting-up time in order to ensure that you have enough time in bed but not too much.
- Of course, if you work shifts, this can be a tremendous problem. Some people seem to be able to manage shift work quite easily, others not. In either case do make sure that you get straight into the new routine as soon as your shift changes; the body isn't normally too upset about occasional changes in the routine so long as you then stick to it for a substantial period of time. Other people simply cannot tolerate, for example, night-shift work. If you are one of those then you might have to take more radical measures like moving on to a job that doesn't entail night-working.
- Come what may, make sure you do everything in your power to get a good night's sleep.

Illness

If you are going through a period of illness, then the chances are that this will affect your mood.

There may not, of course, be a lot you can do about this. Let's assume, in any event, that you are doing all you can in terms of overcoming the illness, regardless of whether it's short-term or long-term, physical or mental.

What we are interested in here is your levels of, and tendency towards, irritability and anger. In that respect there is one major thing you can do: namely, when you find a person who's irritating you and you suspect it may be because of your illness, make sure you lay the blame fair and square on your *illness*, not on the *person*. If you want to swear and curse at anything, do it at the illness rather than the person. And, that being the case, make sure it's under your breath!

There is a very important general rule here: it is always good to lay the blame fair and square where it belongs rather than dumping it on some poor unfortunate who happens to be nearby!

There is just one illness I'd like us to look at more carefully, because it is so often associated with irritability and anger. And that illness is a mental one, namely depression.

Depression

My friend and colleague Paul Gilbert has written an extremely good book on *Overcoming Depression* in this series. However, just for the moment, rather than embark on reading a completely new book, allow me to give you a few tips. That is all they are; but just see if any of these fits your needs.

- Think less, do more. Thinking is one of the great traps in depression. Many people, when they find themselves feeling low, indulge in two types of unhelpful thinking. First, they dwell on and brood over their problems; and second, they 'introspect' – in other words, they think too much about where they might be going wrong. As a general rule, too much thinking doesn't do us any good. Effectively, it digs us deeper into the swamp we are trying to climb out of. Action, on the other hand, is usually helpful. It doesn't particularly matter what the action is. Doing things of any sort seems to be a good idea.
- Envisage a future you want. Regardless of whether you are thinking short-term or long-term, next weekend or ten years hence, looking forward to a good future is a powerful antidepressant. Have a clear picture of what it is you want; write it down or draw pictures of what you're after. But whatever you do, make sure that you have really clear images of the future that you want and how you might obtain it. And do it regularly; it's not a 'once and for all' activity.
- When you do think, be careful what you think *about*. Sometimes people spend time thinking about things that make them unhappy. Sometimes the connection is obvious – thinking about sad things makes most people unhappy. Sometimes it is less obvious; you might, for example, spend time thinking about a good relationship you used to have, but when you stop thinking about it find that you have become unhappy. Try to be aware of what effect your thoughts have on you, and spend less time thinking about things that make you unhappy and more time thinking about things that make you happy.
- Get yourself a good routine with plenty of exercise and sleep, good nutrition, and limited unhelpful drugs. We have probably said enough about this one, but if you get all those things right you're off to a terrific start.
- Act as if you are happy and relaxed. The way we walk, sit, stand and talk gives signals to the brain about how we are. So, it's a good idea to send 'non-depressed' signals to the brain. Try an experiment if you want. Normally, if you're feeling down, you'll be sitting in a depressed kind of way. If somebody came in and saw you, they'd say you *looked* depressed. So, right now, sit

in a non-depressed way. Very quickly, almost immediately, you'll feel the difference. It is very difficult to sit non-depressed and yet *feel* depressed. If you act *as if* you're perfectly happy and relaxed, your brain will, to a degree, follow your lead.

- Have a *good day*. Life consists of a series of days; if you can make each one reasonably good, then you will have a rewarding life. Of course, most days involve some things we don't really want to do and other things we do want to do. The best slogan here is: 'Do the worst first.' That way you're always on the 'downhill run', each thing leading on to something better. If you do it the other way round, you are constantly being 'punished' for everything you do. Also, beware of trying to plan things that will make you happy: you are probably on to a loser here. Happiness is an elusive quality: the more you chase it, the more it runs away from you. It's maybe better to plan things that you think are 'right' or possibly even things that will 'make you feel good about yourself'.
- Sort out your environment. Sometimes when I call on people who have been depressed for a while, I look at where they live and think it's no wonder they're depressed. Any reasonable person, living there, would be depressed. And it's not usually anything to do with money; it's just a badly organized environment. There are three key principles: (1) have things so you feel safe (you're not going to trip up, electrocute yourself, bump into sharp corners, etc.); (2) have things so you are comfortable (chairs, bed, table, work surfaces); (3) have things around you that you like and that make you feel good (specific furniture, pictures, colours, etc.). Take this further if you want. Watch and listen to television and radio programmes that make you feel good rather than bad. Listen to music that makes you feel upbeat rather than down, and so on.
- Sort out your social life. Most people are social beings, so it's important to have this area reasonably well sorted. In the first place, intimate relationships are very important to us, so if you have one it's important to do your level best to make it as good as it can be. Work at developing a good relationship with your partner. For some people this isn't very good, but just get it to its maximum! One word of warning: if you are depressed, you tend to be depressed with your partner (in just the same way as you're probably also depressed with your house, job, car, etc.). This does not mean that your partner is necessarily *causing* your depression. Of course, s/he may be; but be cautious, think carefully before you do or say anything too precipitate.
- Non-intimate relationships are important too. Make them as good as you can. But make them 'real' relationships. In other words, to paraphrase President Kennedy, 'Ask not what your friends can do for you, but what you can do for your friends.' Humans have a rather good design feature whereby if you follow that maxim, your friends benefit a lot *and so do you*. It's a question of cultivating a real interest in your friends rather than 'using them' to provide yourself with a social life.
- 'Gentle up' on yourself. Sometimes people can be really hard on themselves when they are depressed. In fact, sometimes it is the act of being so hard on themselves that causes the depression. They make rules for themselves that are rigid, extreme and over-generalized, rules like: 'I've got to be loved by everybody,' and 'I've got to be 100 per cent perfect in everything I do,' and 'It's terrible if things aren't just the way I want them to be.' To lighten up on yourself, soften these rules to: 'It is nice to have some people who like me (but I can't be liked by everybody),' 'It is nice to do things right (but sometimes things are less than perfect),' 'I'd sooner have things go the way I want them (but then again, that's not always the way life is).' The rules we make for ourselves are often almost unconscious, so sometimes we really have to work hard on softening them up.

DEPRESSION PROJECT

- If you feel you are depressed and your irritability is caused by your depression, then clearly what you need to do is to sort your depression out.
- The points listed above are probably highly relevant for you. You need to go about tackling them methodically. In other words, choose just one of the factors above and really go to town on that one for the next week or two. And then choose another, and then another, until you've covered all the ones that you feel are relevant to you. This is a good major project because clearly it will make you happier and less irritable. Indeed, it can be little short of life-transforming.
- If you want to do a more comprehensive job on your depression, then embark on Paul Gilbert's *Overcoming Depression* (Robinson Publishing, revised edition, 2000) or David D. Burns's *The Feeling Good Handbook* (Plume Publishing, 1990), both of which are excellent guides to escaping from depression.

- Alternatively (or in addition), you can also go along to your doctor and get antidepressants, if you haven't already got them. Modern-day antidepressants are absolutely excellent, and very often you can get the best effect by combining antidepressants with a psychological intervention like that described above or those outlined in the books I've recommended.
- In any case, it's an absolute shame for you to go through life depressed, so set yourself a real project to resolve it. It can be done, even if you've been depressed for ages.

A TIP

Remember, whether your illness is depression or some other affliction, maybe a physical condition, develop the habit whenever you feel irritable of *blaming the illness*, not the person who seems to be causing the irritation.

Life stresses

Stressful life events come in at least two sorts: repetitive stresses such as overwork; and 'once off' events such as bereavement and divorce. Both can affect our mood substantially.

Let's take the repetitive stresses first of all. We are talking here about things such as overwork, demanding family members (such as difficult children, or having to look after an ageing parent), or demanding friends who need your attention. Any one of these can become overwhelming; or pressure from two or more together can add up to the point where it has a serious effect on your mood.

There are three things you can do:

- reduce the stresses;
- learn to cope with the stresses better;
- view the stresses in a different light.

We'll look at these briefly in turn in a moment, but before we do there is one other important point to be made. Again, as with illness, if you are feeling irritable because you are 'stressed out', make sure you put the blame fairly and squarely where it belongs, in other words, on the stresser: overwork, or whatever it happens to be. Don't displace it on to whoever happens to be closest to hand.

Take Ken, for example, our stressed-out executive. Ken is under stress because of his work, not his home life. Even so, because he's stressed, when he goes home to his wife Trish, he is irritable. This means that almost anything that Trish does irritates Ken, not because *she is irritating* but because *he is irritable*. So Ken had to learn to snap *not* at Trish but at his workload. He did this rather clumsily at first. Trish would say something like: 'What should we do for dinner tonight?' and Ken, rather than replying 'I don't care,' in an irritable way, had to teach himself to say: 'All the stuff going on at work is getting me down.' This was pretty strange to Trish at first, because it is a rather odd reply to 'What should we do for dinner tonight?' Nevertheless, Ken got better at it, and eventually was able to say it quietly to himself – making the point that he was stressed out not by Trish but by his work. Further down the line he reduced his work pressures, which was of course the long-term solution.

What I'm trying to say is: blame what deserves to be blamed, rather than the person in front of you. Then, better still, sort out the underlying problem.

So, here goes. The first course of action was to *reduce the stresses*. Most people's

first response to this is ‘easier said than done’, and there is some truth in that. For example, one woman I saw, Alison, had her mother living a few doors down from her, and the mother for very good reasons needed frequent attention. Alison said there was no way that she could give her mother any less attention than she did, so how could she possibly reduce the pressures on her? And she seemed to be correct; her mother really did seem to need the attention described. However, as we talked I learnt that Alison was (a) holding down a fairly demanding job, (b) coming home to a husband and two children and setting about making a traditional evening meal from scratch, and (c) then going off to give her mother the attention she needed. In fact, she also managed to fit in a brief visit to her mother between coming home and setting about making the meal.

So, although she had to continue to give her mother the same amount of attention, Alison could reduce the pressures on herself in other areas. She chose to cut down on the sheer amount of work involved in making the meal. She couldn’t quite bring herself to delegate it to her husband, but she did go for convenience food and that brought her total workload down to a manageable level.

STRESS PROJECT (1)

- If you know you’re being ‘stressed out’ by too many pressures, examine the total pressures you are under and do anything you can to reduce that total. The principal pressure may be unalterable, or alterable only to a small degree. Don’t be put off by that, work on some of the other pressures you are under.
- Also, beware of blocking yourself by *assuming* that the major pressure is unalterable. Frequently, it isn’t, even when it seems to be. Do some careful analysis and see where you can destress yourself.

The second course of action we looked at was *learning to cope with stresses better*. By this I mean you don’t change the number or quantity of stresses affecting you; you simply act differently.

I feel that here I should start telling you about time management, self-instructional training and so forth. On the other hand, I don’t know enough about what particular stresses *you* are under to make such a discussion directly relevant to you. So I will just suggest this:

- try to clarify in your mind exactly what the stresses are (which can be more difficult than at first sight seems);
- then ask several people you know how they cope with those stresses.

For example:

- If you get stressed out by putting two youngsters to bed, neither of whom wants to go and both of whom are liable to be naughty in a hundred and one different ways, ask someone else you know how they cope with it. It doesn’t have to be a contemporary of yours, though it can be if you prefer; it might be someone rather older who knows what they would do ‘if they had their time again’.
- If you are stressed out by having three deadlines to meet and being aware that it is impossible to meet all three, ask somebody else who finds themselves in a similar situation what they do.
- If you are stressed out by having an overenergetic friend who always wants to drag you off to the latest new and exciting place, ask somebody else in a similar situation how they cope with that. Again, it does not have to be an exact parallel. The person you ask might have a friend who is always burdening them with their problems, but has found a method for coping with that. Maybe you could still tailor their solution to your own situation.
- If you are stressed out by being jobless, wanting a job and having too much time on your hands,

again ask other people in the same situation how they cope. Possibly, just possibly, you might be able to put together a solution from the various answers you receive.

STRESS PROJECT (2)

If you feel this is a relevant area for you, do your own 'research project' on how you might cope better with the stresses affecting you. This method hinges on:

- being able to identify very clearly what it is that is stressing you;
- being able to conduct a 'survey' of one or more people who might be able to offer you a solution or a partial solution;
- putting together a personal plan that suits your own situation;
- having the determination to implement that personal plan.

The third solution we had to life's stresses was to *view them in a different way*.

Perhaps you'll excuse a personal example. Just now, even as I write this, I know that I am past the deadline for submitting this book. In fact, I am passed the third deadline set by the publisher, and I think her patience is wearing thin. But then, I can't worry too much about that because I have a whole string of people who would like me to run training courses for their organizations, and I know I am going to disappoint some of them. And then, having faced the wrath of the publisher about this book, and disappointed people who want me to run training courses, I know I'm still way behind on writing up three medico-legal reports (reports where I have interviewed a patient and am submitting my professional opinion to the court).

So, if I had any sense at all I should be completely stressed out, pulled in three directions at once – quite apart from all the 'little extras', like a journalist just having phoned up wanting to know if I have any opinions as to why knitting has suddenly taken off in popularity, what is therapeutic about it and why women do it more than men . . .

And, of course, there *is* a part of me that feels stressed by all of that. But not a very big part, because most of me is thoroughly delighted that (a) a publisher will give me money just for saying I will write a book, (b) so many people are keen for me to run courses for their organizations, and (c) so many solicitors want me to give my opinion on their clients. The knitting question is quite interesting too!

As I'm sure you know, this is known as 'reframing', which simply means seeing the same situation from a different viewpoint. All the 'stresses' are still there, just as they were previously; it's just that they're not viewed as stresses any longer, they're viewed as compliments.

The hurdle you have to get over to use this strategy is that there is a little voice in the back of the head that says you shouldn't be so 'complacent' – in my case, that really I *should* be stressed out by all the things I haven't done and work my socks off until I have caught up. Well, possibly; but the argument against *that* is that such stress is actually counter-productive and means you work less well and achieve what you're trying to achieve more slowly and less successfully.

Let's have another example. I have a friend who has a soft spot for Bangladesh. He has a tremendous amount of empathy for the Bangladeshis and the sufferings they endure by way of floods, storms and winds. He is constantly devastated by the number of people who lose their lives in the country, the amount of suffering that goes on there, and he sends regular sums of money to aid programmes associated with Bangladesh.

However, he is far from solemn about this serious concern, and whenever he hits a

problem, says: ‘Compared with the problems they have in Bangladesh, this is no problem at all.’ And, although he says it in a flippant kind of way, it clearly has a major impact on his thinking. It is his way of ‘reframing’ his own problems.

Obviously, this is simply a variant on the time-honoured admonition, ‘There are plenty of people worse off than you.’ However, it is a very good variant for my friend because it is so much more specific. My friend really does envisage in his own mind trying to explain his problem to somebody in Bangladesh, and how minor and trivial his own problem would seem to them. Very convincing reframing.

REFRAMING PROJECT

- Reframing is a very powerful tool if you can get into it. It has the power to transform a situation quickly and permanently, if you’re prepared to undertake it.
- Use the examples given above to see if there’s a parallel in your own situation. How could you reframe your own situation?
- Note: This is not just an intellectual exercise! Once you have worked out how it is possible to reframe your own situation you then have to go ahead and *do it*. Get yourself in the habit of seeing your situation from this new viewpoint.

Social factors

Being social animals, we humans are greatly affected in our moods by how our social lives are progressing.

There are three major areas we have to consider:

- our most intimate relationships: with our partners if we are adults, more probably with peers, parents or carers if we are children.
- social relationships at work or wherever we occupy ourselves;
- social relationships outside of intimate and work ones, namely with friends, neighbours, etc.

To maintain a good long-term mood we need to nurture each of these three areas as best we can: not just ‘using’ other people to provide ourselves with a social life, but taking a genuine interest in others to give ourselves a solid social foundation.

Inevitably, however, things go wrong in one area or another. For example, you might have trouble with your relationships at work – with your boss, with colleagues, with clients, or whoever. The most common mistake in this instance is to come home and be snappy with those at home. In other words, you transfer problems from one area into a second area, immediately doubling the problem.

An alternative habit is just as easy to get into. We have to take it as given that problems do sometimes arise, so that, inevitably, there will sometimes be difficulties in relationships at work, for example. It is then a question of disciplining ourselves to switch into a different ‘gear’ when we get home: a gear that appreciates the support of those with whom we live, or at least one that takes us into a totally different mode at home from that prevailing at work.

And the same applies the other way round: There are sometimes problems at home that don’t need to be transferred to work or friendships. When one area temporarily goes down, we need to make sure we don’t contaminate the other two areas.

This is exactly the trap that Georgina was walking into. She was the teenager who was depressed and irritable because she had repeated problems with her boyfriends: so, at home, she would be snappy with her parents and her brother because of the

‘boyfriend trouble’. In this way she was alienating the very people who would naturally have provided her with support.

Georgina was a particularly interesting instance to me because she grasped this concept straight away. This was very satisfying to me as a therapist, because I could see the immediate impact of her recognition. Immediately Georgina realized what she was doing, she acted upon the idea that the times when she was sad about her boyfriend situation were the very times when she should put *more* energy into her (good) domestic situation, and the good relationships she had with other friends.

SOCIAL PROJECT

The project in this area has two parts.

- First, if necessary, build your social support in the three areas of intimate relationships, work relationships (if you go to work) and relationships outside of work and intimacy, such as those with neighbours and other friends.
- Second, be constantly aware of the trap of displacing trouble from one of the three areas into another and thereby doubling or trebling your trouble. Skirt your way round this trap by acting upon the realization that when you have trouble in one of the three areas, this is the very time to lean on and nurture the other two areas.

SUMMARY

This has been a big chapter that has looked at the all-pervasive influence of our mood on irritability and anger. It is fluctuations in mood that lead to the unpleasant effect of ‘just feeling irritable’ with no apparent trigger. In fact, when you feel irritable, almost anything can trigger off irritation.

But mood is not random. You can work to produce a good, stable mood by achieving the following:

- Develop a good circadian rhythm or daily routine, particularly in respect of eating and sleeping at regular times.
- Take exercise – any exercise!
- Eat a balanced diet, eat it well, and drink plenty of water.
- Go easy on caffeine (around three cups of instant coffee per day), alcohol (up to 21 units per week if you’re a man, 14 if you’re a woman), nicotine and other ‘recreational’ drugs.
- Develop a pattern of sound, refreshing sleep.
- If your irritable mood is due to illness, it’s a question of clearing up the illness if possible, and if not then making sure you blame your irritability on the illness rather than on the people around you.
- Reduce the stressful effect of life stresses by (a) removing one or more of the stresses – not always the most obvious one; (b) learning to cope with the stresses better, including by asking others how they cope with them; and/or (c) reframing the stresses.
- Nurture the three key areas in your social life and, when you have trouble in one of the three areas, ensure that you don’t spread it to the other two.

PROJECT

- A lot of individual projects have been set out in the course of this chapter. Your task now is an enjoyable one: read through the chapter, decide which are the most relevant areas for you, and undertake the project(s) described under that area.
- Raising your mood is a terrific task to undertake and a very rewarding one indeed. Not only will it make you less irritable, it will permanently brighten up everything around you!

Testing your knowledge

By this stage we have covered all the theory in Part One, and all the techniques for resolving irritability and anger in Part Two. Now it's just a question of applying all this knowledge!

Perhaps you have already applied crucial elements of the programme to your own situation and made some good progress. Or maybe you are planning to set about this in a short while. Either way, it's time now to test yourself out on other people's problems and see how you get on.

To do this, constantly bear in mind the model we have developed, shown again here in Figure 16.1. Use that model to recommend to each of the following people what they should do, as described in the exercise.

Exercise

Below is a list of people, all of whom have problems with irritability and anger. Which of the options covered in Part Two of this book, and summarized here, would you recommend to each of them? You may choose to recommend more than one option for each problem.

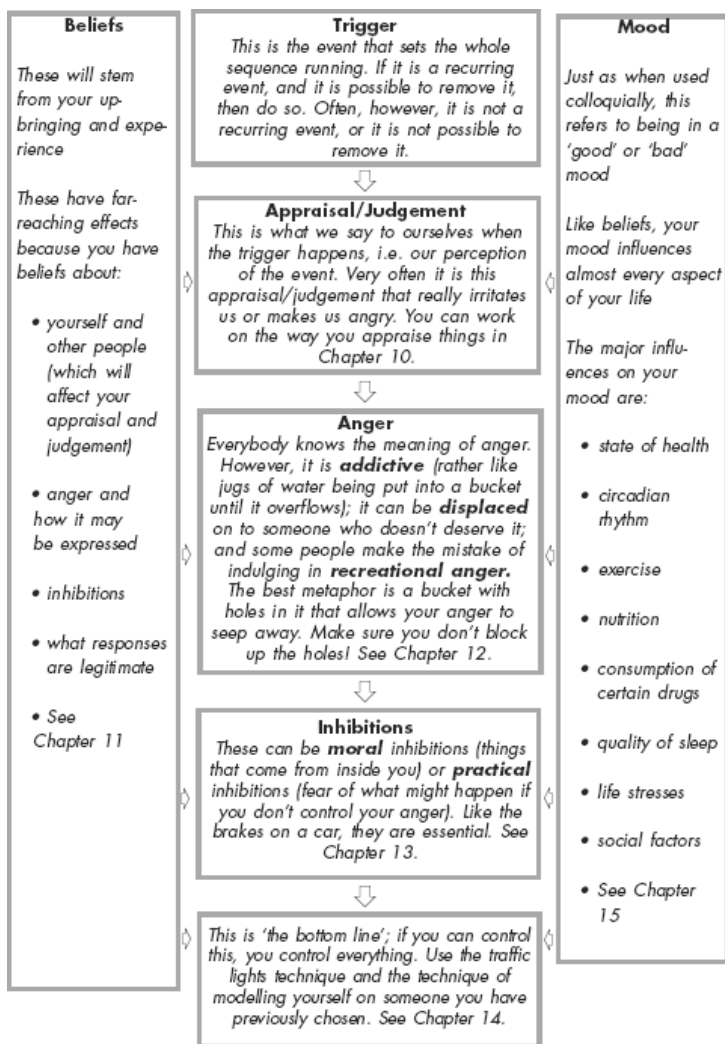


Figure 16.1 A model for analyzing irritability and anger

1 Gerry has noisy next-door neighbours who repeatedly play their music too loud. Over the last three or four months this has made him angrier and angrier until he can hardly control himself. He is now sensitized to the noise and is constantly listening for it. If he has his own stereo on and then thinks he hears loud music from next door he will turn his own stereo down to check.

Which of the following would you recommend?

- He should somehow remove the trigger.
- He should alter his appraisal and judgement of the situation so that he sees it in a different way.
- The trouble is that he is displacing his anger inappropriately, not allowing it to

leak away fast enough, or indulging in recreational anger. He should tackle this.

- (d) He should work at strengthening his inhibitions, both moral and practical.
- (e) He should alter his response to the situation, possibly by using the 'traffic lights' technique or by modelling himself on someone he knows.
- (f) He should work on his beliefs, it is these that are really making him angry and irritable.
- (g) He should work on his mood; sometimes he is in a good mood and sometimes he is in a bad mood and this is the real problem.

2 Colin is really irritated by his neighbours' kids playing football in the street outside his house. Often the ball will go across his lawn and sometimes it even hits his windows. Just like Gerry, he has become increasingly incensed over time and is now constantly on the look-out for the football games to start. His anger is now at a high level and is almost constantly with him.

Which of the following would you recommend?

- (a) He should somehow remove the trigger.
- (b) He should alter his appraisal and judgement of the situation so that he sees it in a different way.
- (c) He is displacing his anger inappropriately, not allowing it to leak away fast enough, or indulging in recreational anger. He should tackle this.
- (d) He should work at strengthening his inhibitions, both moral and practical.
- (e) He should alter his response to the situation, possibly by using the 'traffic lights' technique or by modelling himself on someone he knows.
- (f) He should work on his beliefs, it is these that are really making him angry and irritable.
- (g) He should work on his mood; sometimes he is in a good mood and sometimes he is in a bad mood and this is the real problem.

3 Steve 'blows his top' much more often than he should do. For an example, he tells you about the evening when he was sitting in a bar, near the door, with his friends Ben and Chris. During the course of the evening several people came into the bar and left the door ajar. As it was a cold November evening, each time this happened Steve, Ben and Chris were left in a draft. As the evening wore on, Steve got gradually more angry during the evening until, when a fifth person came in and left the door open, he jumped up and laid into him verbally. However, Steve says this is just one instance of many; he says he's always a bit prone to behave like this, but some days he is much worse than others.

Which of the following would you recommend?

- (a) He should somehow remove the trigger.
- (b) He should alter his appraisal and judgement of the situation so that he sees it in a different way.
- (c) The trouble is that he is displacing his anger inappropriately, not allowing it to leak away fast enough, or indulging in recreational anger. He should tackle this.
- (d) He should work at strengthening his inhibitions, both moral and practical.
- (e) He should alter his response to the situation, possibly by using the 'traffic lights' technique or by modelling himself on someone he knows.
- (f) He should work on his beliefs, it is these that are really making him angry and

irritable.

- (g) He should work on his mood; sometimes he is in a good mood and sometimes he is in a bad mood and this is the real problem.

4 Pam is intensely annoyed by the noise her husband makes when he eats his food. She used to tell him about it, but it seems to have made no difference and she has now given up. The trouble is that now it has come to symbolize what she sees as their incompatibility. Just like Gerry and Colin, she is now sensitized to the noise he makes and almost waits for it at each mealtime. And in truth the pair do seem to be incompatible.

Which of the following would you recommend?

- (a) She should somehow remove the trigger.
- (b) She should alter her appraisal and judgement of the situation so that she sees it in a different way.
- (c) The trouble is that she is displacing her anger inappropriately, not allowing it to leak away fast enough, or indulging in recreational anger. She should tackle this.
- (d) She should work at strengthening her inhibitions, both moral and practical.
- (e) She should alter her response to the situation, possibly by using the 'traffic lights' technique or by modelling herself on someone she knows.
- (f) She should work on her beliefs, it is these that are really making her angry and irritable.
- (g) She should work on her mood; sometimes she is in a good mood and sometimes she is in a bad mood and this is the real problem.

5 Sue says that her son, Ian, drives her mad. She gives an example of how, recently, he dropped a mug on the kitchen floor and broke it, which caused her to completely 'lose it' with him. But she says this is just one example of thousands. She thinks he is careless, but even so she is embarrassed by her overreaction to what she knows are relatively minor events. She also says that on some days she is worse than others.

Which of the following would you recommend?

- (a) She should somehow remove the trigger.
- (b) She should alter her appraisal and judgement of the situation so that she sees it in a different way.
- (c) The trouble is that she is displacing her anger inappropriately, not allowing it to leak away fast enough, or indulging in recreational anger. She should tackle this.
- (d) She should work at strengthening her inhibitions, both moral and practical.
- (e) She should alter her response to the situation, possibly by using the 'traffic lights' technique or by modelling herself on someone she knows.
- (f) She should work on her beliefs, it is these that are really making her angry and irritable.
- (g) She should work on her mood; sometimes she is in a good mood and sometimes she is in a bad mood and this is the real problem.

6 Nigel repeatedly gets angry with his wife, though he does not always vent that anger. The main thing that causes him to become angry is when she contradicts him in public. Frequently the level of these contradictions is very minor (for example, whether a particular event happened on a Wednesday or a Tuesday). It is the

contradiction itself that really gets to him. He can see that in many ways this is a minor thing, and on the one hand feels that he is behaving rather 'childishly' to become so uptight about it. On the other hand he is worried that maybe in some ways his feelings are indicative of something 'deeper' that should be sorted out.

Which of the following would you recommend?

- (a) He should somehow remove the trigger.
- (b) He should alter his appraisal and judgement of the situation so that he sees it in a different way.
- (c) The trouble is that he is displacing his anger inappropriately, not allowing it to leak away fast enough, or indulging in recreational anger. He should tackle this.
- (d) He should work at strengthening his inhibitions, both moral and practical.
- (e) He should alter his response to the situation, possibly by using the 'traffic lights' technique or by modelling himself on someone he knows.
- (f) He should work on his beliefs, it is these that are really making him angry and irritable.
- (g) He should work on his mood; sometimes he is in a good mood and sometimes he is in a bad mood and this is the real problem.

7 Alan, an electrician, is repeatedly incensed by his boss asking him to do 'one more job'. He feels he is being 'put-upon' and taken advantage of. He has never said anything to his boss for fear of harming his future career prospects. Also, there is a part of him that wonders if he is making too much of it; he thinks maybe most people might not be quite as angry as he is if they were in the same situation. In other words, he is concerned he is overreacting. This is slightly paradoxical inasmuch as his boss knows nothing of Alan's inner fury.

Which of the following would you recommend?

- (a) He should somehow remove the trigger.
- (b) He should alter his appraisal and judgement of the situation so that he sees it in a different way.
- (c) The trouble is that he is displacing his anger inappropriately, not allowing it to leak away fast enough, or indulging in recreational anger. He should tackle this.
- (d) He should work at strengthening his inhibitions, both moral and practical.
- (e) He should alter his response to the situation, possibly by using the 'traffic lights' technique or by modelling himself on someone he knows.
- (f) He should work on his beliefs, it is these that are really making him angry and irritable.
- (g) He should work on his mood; sometimes he is in a good mood and sometimes he is in a bad mood and this is the real problem.

8 Georgina, who is seventeen, sometimes gets very depressed and irritable because of 'boyfriend trouble'. She would very much like to be in a stable relationship, but only has occasional boyfriends. This upsets her and she takes it out on her family and friends. They see her as 'moody' and a very irritable young lady. Gradually this has driven many of her friends away.

Which of the following would you recommend?

- (a) She should somehow remove the trigger.
- (b) She should alter her appraisal and judgement of the situation so that she sees it

in a different way.

- (c) The trouble is that she is displacing her anger inappropriately, not allowing it to leak away fast enough, or indulging in recreational anger. She should tackle this.
- (d) She should work at strengthening her inhibitions, both moral and practical.
- (e) She should alter her response to the situation, possibly by using the 'traffic lights' technique or by modelling herself on someone she knows.
- (f) She should work on her beliefs, it is these that are really making her angry and irritable.
- (g) She should work on her mood; sometimes she is in a good mood and sometimes she is in a bad mood and this is the real problem.

9 Danny and Vicky are both well-known figures in the public eye. Danny sometimes gets very angry with Vicky because she says things about their private life which he views as best left unsaid in public.

Which of the following would you recommend?

- (a) He should somehow remove the trigger.
- (b) He should alter his appraisal and judgement of the situation so that he sees it in a different way.
- (c) The trouble is that he is displacing his anger inappropriately, not allowing it to leak away fast enough, or indulging in recreational anger. He should tackle this.
- (d) He should work at strengthening his inhibitions, both moral and practical.
- (e) He should alter his response to the situation, possibly by using the 'traffic lights' technique or by modelling himself on someone he knows.
- (f) He should work on his beliefs, it is these that are really making him angry and irritable.
- (g) He should work on his mood; sometimes he is in a good mood and sometimes he is in a bad mood and this is the real problem.

10 Graham is intensely irritated by his wife, Fiona, flirting with other men – the more so because their friend Ian doesn't seem to be bothered at all by his wife, Hannah, flirting. Nevertheless, it really gets to Graham and he now sees this as a real problem which is threatening their marriage. It doesn't matter what 'mood' he is in, it always gets to him.

Which of the following would you recommend?

- (a) He should somehow remove the trigger.
- (b) He should alter his appraisal and judgement of the situation so that he sees it in a different way.
- (c) The trouble is that he is displacing his anger inappropriately, not allowing it to leak away fast enough, or indulging in recreational anger. He should tackle this.
- (d) He should work at strengthening his inhibitions, both moral and practical.
- (e) He should alter his response to the situation, possibly by using the 'traffic lights' technique or by modelling himself on someone he knows.
- (f) He should work on his beliefs, it is these that are really making him angry and irritable.
- (g) He should work on his mood; sometimes he is in a good mood and sometimes he is in a bad mood and this is the real problem.

11 Brian has very serious problems with his anger; so much so that it sometimes lands him in front of the courts and indeed in prison. The most severe example is where he was drinking in a bar one night when a man next to him jogged his elbow so that Brian spilt beer down himself. Brian jumped to the conclusion that the man had done this deliberately to somehow show him up and make a fool of him. His anger was immediate and, without thinking, he smashed his beer-mug against the bar and pushed the broken mug into the other man's face. Or at least, this is how he recollects it. He is now serving a five-year prison sentence.

Which of the following would you recommend?

- (a) He should somehow remove the trigger.
- (b) He should alter his appraisal and judgement of the situation so that he sees it in a different way.
- (c) The trouble is that he is displacing his anger inappropriately, not allowing it to leak away fast enough, or indulging in recreational anger. He should tackle this.
- (d) He should work at strengthening his inhibitions, both moral and practical.
- (e) He should alter his response to the situation, possibly by using the 'traffic lights' technique or by modelling himself on someone he knows.
- (f) He should work on his beliefs, it is these that are really making him angry and irritable.
- (g) He should work on his mood; sometimes he is in a good mood and sometimes he is in a bad mood and this is the real problem.

12 Paul gets very frustrated in bringing up his 12-year-old son. He gives the example of how, recently, he found that the boy had lied to him about having done his homework: although he said he had done it, in fact he had not. This led to Paul impulsively hitting his son across the face and sending him to his room for the rest of the evening. It took them days to recover from this episode. Paul describes how sometimes he would take such an incident in his stride, but other times he reacts angrily in this way. He thinks that the variation is sometimes caused by what has happened at work, in that when he has had a bad day he sometimes takes it out on his son. He also thinks there are times when he is just in a bad mood. In any event, he is very worried about the boy's future, with the result that if he doesn't do his homework Paul takes it very hard.

Which of the following would you recommend?

- (a) He should somehow remove the trigger.
- (b) He should alter his appraisal and judgement of the situation so that he sees it in a different way.
- (c) The trouble is that he is displacing his anger inappropriately, not allowing it to leak away fast enough, or indulging in recreational anger. He should tackle this.
- (d) He should work at strengthening his inhibitions, both moral and practical.
- (e) He should alter his response to the situation, possibly by using the 'traffic lights' technique or by modelling himself on someone he knows.
- (f) He should work on his beliefs, it is these that are really making him angry and irritable.
- (g) He should work on his mood; sometimes he is in a good mood and sometimes he is in a bad mood and this is the real problem.

13 Tina has a problem with 'bouncers', doormen at nightclubs. She describes herself as a person who 'speaks her mind' generally, but with doormen it goes beyond that. She says that she doesn't really go looking for trouble, but somehow or other she seems to repeatedly get into arguments with them. As a result she has been in numerous scuffles, and on three occasions it would be more accurate to say that Tina has assaulted the doormen in question. Rather strangely, perhaps, while she has assaulted three different doormen and been in scuffles with numerous others, she doesn't get into physical fights with anybody else.

Which of the following would you recommend?

- (a) She should somehow remove the trigger.
- (b) She should alter her appraisal and judgement of the situation so that she sees it in a different way.
- (c) The trouble is that she is displacing her anger inappropriately, not allowing it to leak away fast enough, or indulging in recreational anger. She should tackle this.
- (d) She should work at strengthening her inhibitions, both moral and practical.
- (e) She should alter her response to the situation, possibly by using the 'traffic lights' technique or by modelling herself on someone she knows.
- (f) She should work on her beliefs, it is these that are really making her angry and irritable.
- (g) She should work on her mood; sometimes she is in a good mood and sometimes she is in a bad mood and this is the real problem.

14 Ken describes himself as 'stressed out'. He has what most people would regard as a high-powered job, and has somewhat more work than he can cope with. This leads to him feeling bad during the day and, just occasionally, 'snapping people's heads off', as he puts it. However, what worries him most is how irritable he is back home. He feels sorry for his wife Trish having to live with him like this, but says that he cannot help it.

Which of the following would you recommend?

- (a) He should somehow remove the trigger.
- (b) He should alter his appraisal and judgement of the situation so that he sees it in a different way.
- (c) The trouble is that he is displacing his anger inappropriately, not allowing it to leak away fast enough, or indulging in recreational anger. He should tackle this.
- (d) He should work at strengthening his inhibitions, both moral and practical.
- (e) He should alter his response to the situation, possibly by using the 'traffic lights' technique or by modelling himself on someone he knows.
- (f) He should work on his beliefs, it is these that are really making him angry and irritable.
- (g) He should work on his mood; sometimes he is in a good mood and sometimes he is in a bad mood and this is the real problem.

15 Chris says that he 'changes into a different person' when he gets in the car. From his account it would appear that he is responsible for 99 per cent of all of the nation's road rage incidents! Somebody only has to drive in a way that he takes exception to and his instant response is to tailgate or intimidate them. He knows this is wrong but 'cannot help himself'. This is the only area that he has problems with.

Which of the following would you recommend?

- (a) He should somehow remove the trigger.
- (b) He should alter his appraisal and judgement of the situation so that he sees it in a different way.
- (c) He is displacing his anger inappropriately, not allowing it to leak away fast enough, or indulging in recreational anger. He should tackle this.
- (d) He should work at strengthening his inhibitions, both moral and practical.
- (e) He should alter his response to the situation, possibly by using the 'traffic lights' technique or by modelling himself on someone he knows.
- (f) He should work on his beliefs, it is these that are really making him angry and irritable.
- (g) He should work on his mood; sometimes he is in a good mood and sometimes he is in a bad mood and this is the real problem.

Most of these cases are based on people I have seen in my professional capacity (with the notable exception of Danny and Vicky), so obviously I have changed their names and minor details (again with the exception of Danny and Vicky) to make them unidentifiable. I should stress that in the case of 'Danny and Vicky' I have no inside knowledge as to what irritates either of them or how they resolve matters between them.

The fact that I have seen most of the others professionally means that I feel I have 'the right answers'. It would be misleading to give these, however, because usually, there is more than one possible answer to the same problem. In fact, rather as a broken-down car is best pushed by several people, problems concerning irritability and anger are best tackled by means of several solutions. So it may be that, for a given case, a combination of two or more of the seven factors would work best.

So, ponder on some of these examples and discuss them with friends and relatives – who knows, you may produce the perfect answers!

PROJECT

Write out your own irritability/anger problem in a similar way to the fifteen examples given here. Then analyze it using the same seven questions (a)–(g). You now have your action plan!

Good Luck!

I hope you've enjoyed reading this book and, more to the point, I hope you have found it useful. I have certainly enjoyed writing it and confess to being pleased with the result. I think you have all the information here necessary to sort out your irritability or anger successfully and permanently.

Maybe, indeed, you have done so already, just in the course of your first reading. This is especially likely if you have chosen the projects carefully for yourself and implemented them thoroughly.

A word of caution and encouragement, however. Old habits die hard, and you may very well find that you have to reread parts of this book over months and even years to maintain your success. Indeed, I would urge you to do that, because the more pieces of the jigsaw you get in place, the easier it is to see a good clear picture. It may be that, when you first read through the book, you just 'cream off' the most relevant bits for yourself. On rereading you might implement other bits that are relevant, but not quite so relevant as the first level. This is still well worth doing, however, because it makes the whole process clearer and easier. So, do reread, lots of times if you want, because the projects are good ones and will really sort things out for you if you follow them through.

And one final thought: You probably embarked on this book out of consideration for those around you – and very commendable that is. Nevertheless, I hope you find that it has done wonders for your own enjoyment of life, too!

Appendix

Diary 1

Keep a record of when you get irritable or angry. Fill it in as soon as possible after the event. Note as clearly as possible what triggered your irritability/anger, and how you responded

TRIGGER (INCLUDE DAY, DATE AND TIME)

RESPONSE (WHAT DID YOU DO?)

Diary 1: Fill in as soon as possible after the event

TRIGGER (INCLUDE DAY, DATE AND TIME)

RESPONSE (WHAT DID YOU DO?)

Diary 1: Fill in as soon as possible after the event

TRIGGER (INCLUDE DAY, DATE AND TIME)

RESPONSE (WHAT DID YOU DO?)

Diary 1: Fill in as soon as possible after the event

TRIGGER (INCLUDE DAY, DATE AND TIME)

RESPONSE (WHAT DID YOU DO?)

Diary 1: Fill in as soon as possible after the event

TRIGGER (INCLUDE DAY, DATE AND TIME)

RESPONSE (WHAT DID YOU DO?)

Diary 2

Fill this in as soon as possible after each time you get irritable or angry

Trigger: Describe here what a video camera would have seen or heard. Include the day and date, but do not put what you thought or how you reacted.

Appraisal/Judgement: Write here the thoughts that went through your mind, as clearly as you can remember them.

Anger: Leave this blank for the time being.

Inhibitions: Leave this blank for the time being.

Response: Write here what a video camera would have seen you do and heard you say, as clearly as you can.

More helpful appraisal/judgement: How else might you have appraised the situation? To determine this, you might like to consider the following: What errors are you making (selective perception, mind-reading, awfulizing, emotive language, overgeneralization)?

If you had an all-knowing, all-wise friend, how would s/he have seen the situation?

Is a reframing of the situation possible? (A glass that is half empty is also half full.)

What would your cost-benefit analysis be of seeing the situation the way you did?

Diary 2

Fill this in as soon as possible after each time you get irritable or angry

Trigger: Describe here what a video camera would have seen or heard. Include the day and date, but do not put what you thought or how you reacted.

Appraisal/Judgement: Write here the thoughts that went through your mind, as clearly as you can remember them.

Anger: Leave this blank for the time being.

Inhibitions: Leave this blank for the time being.

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What would your cost-benefit analysis be of seeing the situation the way you did?

Useful Resources

Organizations

Great Britain

British Association of Behavioural and Cognitive Therapies (BABCP)

The Globe Centre

PO Box 9

Accrington BB5 0XB

Tel: 01254 875 277

Email: babcp@babcp.com

Website: www.babcp.com

British Association for Counselling and Psychotherapy (BACP)

BACP House

15 St John's Business Park

Lutterworth

Leicestershire LE17 4HB

Tel: 0870 443 5252

Email: bacp@bacp.co.uk

Website: www.bacp.co.uk

MIND: The National Association for Mental Health

Granta House

15–19 Broadway

Stratford

London E15 4BQ

MindinfoLine: 0845 766 0163

Email: contact@mind.org.uk

USA

**The Association for Behavioral and
Cognitive Therapies (ABCT)
(Formerly the Association for the
Advancement of Behavior Therapy)**

305 7th Avenue
16th Floor
New York NY 10001

Tel: 001 212 647 1890
Fax: 001 212 647 1865
Website: www.aabt.org

Institute for Behavior Therapy

104 East 40th Street
Suite 206
New York NY 10016

Tel: 001 212 692 9288
Fax: 001 212 692 9305

Online services

www.wrongdiagnosis.com/sym/irritability.htm

www.cwgsy.net/community/mindinfo/anger.htm

www.mentalhelp.net

Click on 'Read & Listen' and select 'Psychological Self Tools eBook'

www.moodjuice.scot.nhs.uk/anger.asp

www.ezinearticles.com

Select 'Self Improvement' from 'Article Categories' and then 'Anger Management' and look up article 'Self Help Anger Management' by John Sullivan.

Useful books

Clark, Lynn *SOS Help for Emotions: Managing Anxiety, Anger, and Depression*, Parents Press (2001).

Gentry, W. Doyle *Anger Management for Dummies*, John Wiley & Sons (2006).

Lener, Harriet Goldhor *The Dance of Anger: A Woman's Guide to Changing the Patterns of Intimate Relationships*, HarperCollins (2005).

Peurifoy, Reneau *Anger: Taming the Beast: A Step-by-Step Program for Managing Anger Calmly and Effectively*, Kodansha America (2007).

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OVERCOMING DEPRESSION

A self-help guide using Cognitive Behavioral Techniques

PAUL GILBERT

ROBINSON
London

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Preface to the first edition

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Acknowledgments

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Last but of course not least, many thanks to my supportive family, Jean, Hannah and James, perhaps the biggest antidote to depression.

I would like to dedicate this book to all depressed people: may compassion help you light a candle in your darkness. I offer my immense gratitude to all those depressed people who have been honest and open and have educated and guided me in my therapeutic efforts.

Foreword

Many, perhaps the majority, of those who go to see their family doctor have some type of psychological problem which makes them anxious or unhappy. There may be a fairly obvious reason for this – the loneliness of widowhood or the stresses of bringing up a family – or it may be that their mental state is part of their personality, something they were born with or a reaction to traumatic experiences in their lives. Despite being so common, I soon discovered after starting in general practice over ten years ago that this type of mental disturbance (usually described as a *neurosis* to distinguish it from the *psychosis* of those with a serious mental illness like schizophrenia) is particularly difficult to deal with. What are the options? Well, there are always drugs – minor tranquillizers, antidepressants and sleeping pills. It is certainly easy enough to write a prescription and more often than not the patient feels a lot better as a result, but there is no getting away from the fact that drugs are a chemical fix. Sometimes this is all that is necessary to tide someone over a difficult period, but more usually the same old problems recur when the drugs are discontinued.

The alternatives to drugs are the ‘talking therapies’ ranging from psychoanalysis to counselling that seek to sort out the underlying cause of anxiety or unhappiness. Psychoanalysis is out of the question for many, being too prolonged – often lasting for years – and too expensive. Counselling certainly can be helpful for no other reason than that unburdening one’s soul to a sympathetic listener is invariably therapeutic. But once the counselling sessions were over, I got the impression it was only a matter of time before the psychological distress reappeared.

Here, then, is one of the great paradoxes of modern medicine. Doctors can now transplant hearts, replace arthritic hips and cure meningitis but, confronted by the commonest reason why people seek their advice, they have remarkably little to offer. And then a couple of years ago I started to hear about a new type of psychological treatment – cognitive therapy – which, it was claimed, was not only straightforward but demonstrably effective. I was initially sceptical as I found it difficult to imagine what sort of breakthrough insight into human psychology should lie behind such remarkable claims. The human brain is, after all, the most complex entity in existence, so it would seem unlikely that someone had suddenly now at the end of the twentieth century found the key that unlocked the mysteries of neuroses – a key that had eluded human understanding for hundreds of years.

The central insight of cognitive therapy is not, it emerges, a new discovery, but rather is based on the profound observation originally formulated by the French philosopher Descartes that the essential feature of human consciousness was ‘*cogito ergo sum*’ – ‘I think therefore I am.’ We *are* our thoughts and the contents of our thoughts have a major influence on our emotions. Cognitive therapy is based on the principle that certain types of thought that we have about ourselves – whether, at its simplest, we are loved or wanted or despised or boring – have a major effect on the

way we perceive the world. If we feel unloved, the world will appear unloving, and then every moment of every day our sense of being unloved is confirmed. That, after all, is what depression is all about. These types of thoughts are called 'automatic thoughts' because they operate on the margins of our consciousness as a continual sort of internal monologue. If these thoughts are identified and brought out into the open then the state of mind that they sustain, whether anxiety or depression or any of the other neuroses, can begin to be resolved.

So this type of therapy is called 'cognitive' because it is primarily about changing our thoughts about ourselves, the world and the future. The proof of the pudding, as they say, is in the eating and the very fact that this type of therapy has been shown to work so well, in countless well-controlled studies, is powerful confirmation that the underlying insight that our thoughts lie behind, and sustain, neurotic illnesses is in essence correct.

Nonetheless, some may be forgiven for having misgivings. The concept of cognitive therapy takes some getting used to and it is certainly hard to credit that complex psychological problems can be explained by such an apparently simple concept. There is perhaps an understandable impression that it all sounds a bit oversimplified or trite, that it fails to get to the root cause of the source of anxiety or depression.

So it is necessary to dig a bit deeper to examine the origins of cognitive therapy and perhaps the easiest way of doing this is to compare it with what for many is the archetype of all forms of psychotherapy – psychoanalysis. Psychoanalysis claims to identify the source of neuroses in the long-forgotten and repressed traumas of early childhood, so it is less concerned with thoughts themselves than with the hidden meaning which (it claims) underlies them. The important question, though, is whether psychoanalysis does make people better, or at least less unhappy. Many people certainly believe they have been helped, but when Professor Gavin Andrews of the University of New South Wales reviewed all the studies in which the outcome of psychoanalysis had been objectively measured in the *British Journal of Psychiatry* in 1994, he was unable to show that it worked any better than 'just talking'.

In cognitive therapy, the importance of human thoughts lies precisely in their content and how that influences the way a person feels about themselves, a point well illustrated by one of its early pioneers, Aaron Beck. Back in the sixties, while practising as a psychoanalyst in Philadelphia, Beck was treating a young woman with an anxiety state which he initially interpreted in true psychoanalytic fashion as being due to a failure to resolve sexual conflict arising from problems in childhood. During one session he noticed that his patient seemed particularly uneasy and, on enquiring why, it emerged she felt embarrassed because she thought she was expressing herself badly and that she sounded trite and foolish. 'These self-evaluative thoughts were very striking,' Beck recalled, 'because she was actually very articulate.' Probing further he found that this false pattern of thinking – that she was dull and uninteresting – permeated all her relationships. He concluded that her chronic anxiety had little to do with her sex life but rather arose from a constant state of dread that her lover might desert her because he found her as uninteresting as she thought herself to be.

Over the next few years, Beck found that he was able to identify similar and quite predictable patterns of thinking in nearly all his patients. For the first time he realized that he was getting inside his patients' minds and beginning to see the world as they

experienced it, something he had been unable to do in all his years as a psychoanalyst. From that perspective he went on to develop the principles of cognitive therapy.

Compared to psychoanalysis, cognitive therapy certainly does appear much simpler, but we should not take this to mean that it is less profound. The central failure of the founders of psychoanalysis was that they did not recognize the true significance of thoughts in human neurosis. Once that significance was grasped by those like Aaron Beck then human psychological disorders became more readily understandable and therefore simpler, but it is the simplicity of an elegant scientific hypothesis that more fully explains the facts. It can't be emphasized too strongly the enormous difference that cognitive therapy has made. Now it is possible to explain quite straightforwardly what is wrong in such a way that people are reassured, while allowing them to be optimistic that their problems can be resolved. Here, at last, is a talking therapy that works.

Professor Gavin Andrews in his review in the *British Journal of Psychiatry* identified cognitive therapy as 'the treatment of choice' in generalized anxiety, obsessive compulsive disorders and depression. It has in addition been shown to be effective in the treatment of eating disorders, panic attacks and even in the management of marital and sexual difficulties, in chronic pain syndromes and many emotional disorders of childhood. Its contribution to the alleviation of human suffering is remarkable.

James Le Fanu, GP

Introduction

Why a cognitive behavioral approach?

The approach this book takes in attempting to help you overcome depression is a 'cognitive-behavioral' one. A brief account of the history of this form of intervention might be useful and encouraging. In the 1950s and 1960s a set of therapeutic techniques was developed, collectively termed 'behavior therapy'. These techniques shared two basic features. First, they aimed to remove symptoms (such as anxiety) by dealing with those symptoms themselves, rather than their deep-seated underlying historical causes (traditionally the focus of psychoanalysis, the approach developed by Sigmund Freud and his associates). Second, they were scientifically based, in the sense that they used techniques derived from what laboratory psychologists were finding out about the mechanisms of learning, and they put these techniques to scientific test. The area where behavior therapy initially proved to be of most value was in the treatment of anxiety disorders, especially specific phobias (such as extreme fear of animals or heights) and agoraphobia, both notoriously difficult to treat using conventional psychotherapies.

After an initial flush of enthusiasm, discontent with behavior therapy grew. There were a number of reasons for this, an important one of which was the fact that behavior therapy did not deal with the internal thoughts which were so obviously central to the distress that many patients were experiencing. In particular, behavior therapy proved inadequate when it came to the treatment of depression. In the late 1960s and early 1970s a treatment for depression was developed called 'cognitive therapy'. The pioneer in this enterprise was an American psychiatrist, Professor Aaron T. Beck. He developed a theory of depression which emphasized the importance of people's depressed styles of thinking, and, on the basis of this theory, he specified a new form of therapy. It would not be an exaggeration to say that Beck's work has changed the nature of psychotherapy, not just for depression but for a range of psychological problems.

The techniques introduced by Beck have been merged with the techniques developed earlier by the behavior therapists to produce a therapeutic approach which has come to be known as 'cognitive behavioral therapy' (or CBT). This therapy has been subjected to the strictest scientific testing and has been found to be highly successful for a significant proportion of cases of depression. In recent years, one variation on CBT for depression has been the introduction of 'mindfulness' techniques. Another has been the appreciation of the importance of compassion in overcoming depression. Both of these innovations are dealt with extensively within this new edition of *Overcoming Depression*.

It has now become clear that specific patterns of disturbed thinking are associated with a wide range of psychological problems, not just depression, and that the treatments which deal with these are highly effective. So, effective cognitive

behavioral treatments have been developed for a range of anxiety disorders, such as panic disorder, generalized anxiety disorder, specific phobias, social phobia, obsessive compulsive disorders, health anxiety, as well as for other conditions such as drug addictions, and eating disorders like bulimia nervosa. Indeed, cognitive behavioral techniques have been found to have an application beyond the narrow categories of psychological disorders. They have been applied effectively, for example, to helping people with weight problems, couples with marital difficulties, as well as those who wish to give up smoking or deal with drinking problems. They have also been effectively applied to dealing with low self-esteem.

The starting-point for CBT is the realization that the way we think, feel and behave are all intimately linked, and changing the way we think about ourselves, our experiences, and the world around us changes the way we feel and what we are able to do. So, for example, by helping a depressed person identify and challenge their automatic depressive thoughts, a route out of the cycle of depressive thoughts and feelings can be found. Similarly, habitual behavioral responses are driven by a complex set of thoughts and feelings, and CBT, as you will discover from this book, by providing a means for the behavior, thoughts and feelings to be brought under control, enables these responses to be undermined and a different kind of life to be possible.

Although effective CBT treatments have been developed for a wide range of disorders and problems, these treatments are not currently widely available; and, when people try on their own to help themselves, they often, inadvertently, do things which make matters worse. In recent years, experts in a wider range of areas have taken the principles and techniques of specific cognitive behavioral therapies for particular problems and presented them in manuals (the *Overcoming* series) which people can read and apply themselves. These manuals specify a systematic program of treatment which the person works through to overcome their difficulties. In this way, cognitive behavioral therapeutic techniques of proven value are being made available on the widest possible basis.

The use of self-help manuals is never going to replace the need for therapists, and many people with emotional and behavioral problems will need the help of a qualified professional. It is also the case that, despite the widespread success of cognitive behavioral therapy, some people will not respond to it and will need one of the other treatments available. Nevertheless, although research on the use of these self-help manuals is at an early stage, the work done to date indicates that for a large number of people, such a manual is sufficient for them to overcome their problems without professional help. Sadly, many people suffer on their own for years. Sometimes they feel reluctant to seek help without first making a serious effort to manage on their own. Often they feel too awkward or even ashamed to ask for help. It may be that appropriate help is not forthcoming, despite their best efforts to find it. For many of these people, the cognitive behavioral self-help manual will provide a lifeline to a better future.

Peter J Cooper

The University of Reading, 2009

Preface to the third edition

Bringing compassion to our practice

When Nick Robinson invited me to prepare a third edition of *Overcoming Depression* I was both delighted and daunted. I was delighted because it is over 10 years since the second edition was written and so much has happened in that time in regard to working with depression. I was daunted because I knew there would have to be a fairly substantial rewriting. So, over a year and many five o'clock in the mornings later, here we are.

What is so new that we should get excited? One thing is that the past 10 years has seen a major focus on what is called *mindfulness*. Mindfulness was originally developed within ancient spiritual traditions in the East. Like many other traditions, it proposes that our attention and thoughts contribute to our well-being or distress. It teaches ways to attend to the thoughts and feelings in our minds by becoming more observant and non-judgemental. It also provides various 'exercises' we can practise, which help to balance our state of mind. There is increasing research evidence that this can be extremely helpful to us when we are depressed (and throughout our lives). It is particularly helpful when we tend to avoid our feelings or ruminate on them or judge them to be bad or overwhelming. Chapter 7 is dedicated to this approach.

The second major excitement is the way that our understanding of *compassion* has developed in the past 10 years. We are learning how we can develop it as a major antidote to depression. There is increasing evidence that training ourselves in compassion and kindness, with regular practice, can actually change our brains. Researchers are now exploring this in detail.

This is exciting, because humans have evolved to be very responsive to kindness. For example, babies don't survive or grow without care and support. If we think about times when we're distressed, it is easy to recognize that the kindness of others helps to soothe us and pull us through. We have also discovered that individuals who are kind and supportive to themselves are also more resilient to life's difficulties than those who are critical and self-condemning. Our brain does not respond very well to self-criticism.

In the preface to the first edition, written 15 years ago, I wrote that 'I see depression as a state of mind that we have a potential for, just as we have a potential to feel grief, fear, sexual arousal and so forth. And like any state of mind, depression is associated with very real changes in the brain.' I went on to say that depression is a brain state and a brain pattern that can affect any of us to differing degrees. Once we know this, then all efforts can be aimed at changing this brain pattern, trying to shift brain states (discussed on my CD *Overcoming Depression*). This is where kindness comes in again, because in Chapter 2 I outline in detail how our emotional systems work to create different patterns and states of mind. I also describe how a combination of mindfulness and compassion can help balance them.

The key message is that there are many ideas to help us when depression grabs hold of our feelings, thoughts and behaviors. We can however learn to act against the desire to withdraw that operates within depression. We can stand back and view our thoughts from the balcony, as it were, and develop a balanced perspective rather than an overly hostile, critical or pessimistic one. We can learn to develop and seek out helpful and supportive relationships.

Whatever we choose to do to bring more balance to our minds, if we learn to do it with the feelings and intentions of kindness, support and encouragement, recognizing how painful and hard depression is, we are more likely to be successful. When we allow ourselves to feel compassionate – and for some people that is quite a big step – we open ourselves up to being helped and to healing things we may be ashamed of.

Many of the original ideas are still core to this book, but they are now more linked to the importance of compassion for oneself and others, and how to develop it. If you like this approach you may want to pursue it further in other writings, or perhaps further your own explorations into its healing properties.

You will see that as in the previous editions I use a lot of case material. For confidentiality reasons I can only include stories that people have agreed I can use; elsewhere I have combined themes and created fictional characters. To protect confidentiality they are designed to be non-identifiable, and are used primarily to create a narrative that helps the reader's understanding.

I know this a long book but we cover a lot of ground, and you can easily dip in and out of it. Good luck.

Preface to the first edition

Sadly, some people seem at risk of certain types of depression, and we now know that genes appear to play a role. However, while I do not want to underplay the biological dimension of depression, some forms are surprisingly common and genes probably play a major role only in a minority of cases. Life events and early childhood experiences seem by far the more common sources. I suspect this was true for me. My early years were spent in West Africa. It was a place of tremendous freedoms and I would roam happily in the outback. For nearly a year we lived in the 'bush' with no running water or electricity – and no school! My memories are still vivid of that time and when the skies are dull and cold I remember with great fondness the excitements, the blue skies and expansiveness of Africa. When I came home to England to go to boarding school I found the confinement and harshness of it difficult. I also found that I was behind in my education and had serious problems with the English language. To this day I do not like confinements and can easily feel trapped in places. The life events that triggered my depression were all related to feeling trapped and failing.

I see depression as a state of mind that we have a potential for, just as we have the potential to feel grief, fear, sexual arousal and so forth. And like any state of mind, depression is associated with very real changes in the brain. In my own work I have explored the reasons for this by thinking about the typical things that tend to trigger depression. This led to a consideration of whether the capacity for depression might be something that evolved along with us as we plodded the conflict-ridden trail from reptiles to monkey to humans. I won't go into the details of that except to say that depression probably affects animals. As with humans, depression seems to strike mostly when an animal loses status (is defeated), loses control and/or is trapped in adverse environments. When these things happen the brain seems to switch into depressed-like states. In humans, signals of being valued as a person have evolved as important mediators of mood states.

The other thing to consider, if we stay with an evolutionary view for a moment, is that although the brain is a highly complex organ it is also something of a 'contraption'. Deep in our brains are structures that evolved with the reptiles. Neuropsychologists even called this part of the brain 'the reptilian brain'. Evolution does not create totally new designs. Rather, old designs are adapted, added to or altered as a species evolves. It is rather like developing a car, but each new design must include the old – you can't go back to the drawing board and start afresh. So the brain has various structures within it that stretch way back many millions of years. This is why we can see the brain as a cobbling together of different bits that do different things. We have the potential for great violence, terror, lust, love and compassion. We are a mosaic of possibilities arising out of this jerry-built brain of

ours.

Provided these various parts of the brain work together then it functions reasonably well, but if they get out of balance then it functions less well. Due perhaps to childhood trauma or difficulties and later stressful life events, we sometimes find it difficult to keep this mixed array of possibilities under control. They start pulling in different directions. The brain may tell us that there is far more danger than there is, and we panic; it may tell us that we are inferior, worthless and to give in, and we feel depressed; it may tell us that we need to get our own back, and so we seethe with the desire for revenge. Each of these parts has its own job to do, but they must work in harmony. In depression we lose this harmony and have thoughts and ideas that lead us to feel more defeated, inferior and worthless, and thus more depressed.

What we find in depression is that people experience all kinds of thoughts and feelings coming from different systems within the brain, and these can be difficult to control or make sense of. Another way to think of this is that we have different parts to ourselves and can play different roles, e.g. child, hero, lover, parent, friend, enemy, helper and so on. Evolution has provided many brain systems that enable us to enact different roles. Each part tends to see the world in its own way. For example, the hero part strides out and risks all. The coward part says, 'You must be joking. I'm not going out there.' Now if the two work together then they will make a sensible compromise and evaluation of risk. But if the hero does not listen to the coward then the hero puts the self in danger. On the other hand, if the coward does not listen to the hero, the coward just hides in the corner. In reality, of course, there are no actual 'parts' as such; what we experience is the activation, to a greater or lesser degree, of different brain systems. When we pay attention to our thoughts and feelings we can actually recognize which brain systems are turned on. Our thoughts and feelings are windows on these different systems in us.

So what to do if you feel depressed? The first thing to say is that the thoughts we have when we are depressed tell us that the depression system is switched on. That may not seem very helpful, until we realize that there may be ways to turn it off again and bring ourselves back into balance. For example, when we are depressed we may think in ways that seem right 'to the depression', but which may seem very wrong to other parts of ourselves. The rational and compassionate parts of ourselves may have a very different view of things. The more we can say, 'OK, my depression is a part of me; one of my many brain systems, but it can't be relied on to be accurate or helpful', the more we can step in to try to take control of it.

Second, as we get depressed the depression system tends to throw other systems out of balance. For example, we may become more irritable or anxious. And as a result we may judge ourselves and/or others more harshly, which feeds the depression. Typical of depression is to devalue things, usually ourselves and accomplishments, but we may also devalue others. We may start to believe that things are darker than they are.

Third, depression is about how the brain is operating at any particular time. So depression is very much felt 'in the body' and is about feelings. Depression was designed (evolved) to slow us down, to weaken self-confidence and make us more sensitive to possible social losses and threats. It does this by changing the way our bodies work. However, if we can get other systems to challenge the depression, by learning how to think differently about ourselves and events, then we have an opportunity to get things back into balance. This book will discuss how to recognize

important depressing thoughts to work with and how to challenge them.

This book is for people who would like to know more about depression – what it is and how to help oneself. It is not a cure-all, nor a substitute for therapies like drugs or psychotherapy, nor can a book like this change the painful realities of living. It is simply one approach. Each person's depression is, in part, similar to other people's and in part unique to that person. What understanding can do is to offer a way to move out of depression rather than plunge further into it. There are many ways to challenge some of the negative thinking of depression. I will try to point out some pitfalls to watch out for and suggest some methods that will enable you to develop a more rational and compassionate approach to yourself.

The book is divided into three parts. The first is the most technical. I have included this because many of the depressed people I see say that they would like to know more about depression itself. If it seems too technical, you can skip those bits you find difficult to follow; in fact, you can skip the whole of Part I if you like. Part II outlines some basic approaches to self-help. Here we will explore the role of thoughts and feelings, and how to challenge some of the thoughts and feelings that lead to a downward slide. There is a chapter devoted to how depressed people treat themselves (which is often very badly) and how to treat yourself more kindly. The more you learn to value yourself (or at least to stop devaluing yourself), the greater the chances of turning the depression system off. Each chapter in Part II is followed by a series of exercises you can try. In Part III the basic approaches covered in Part II are applied to special problems. These include the need for approval, anger, shame, lack of assertiveness, disappointment and perfectionism.

You will read of many other people's depression. All names have, of course, been changed. Also, to avoid any chance of identification, the details of all the stories have been altered. Sometimes two or three cases have been rolled into one, again to avoid identification. The focus of each problem is on the specific themes that reveal the dilemmas and complexities of depression.

Our journey together may be a long one, but I hope it will equip you with some ideas of how to move out of depression. Recovering from depression usually requires time, effort and patience, but if you know what you are trying to achieve, and have a way forward, you are likely to be more successful in your efforts. So let's begin.

PART ONE

Understanding Depression

What is depression?

If you suffer from depression, you are, sadly, far from being alone. In fact, it has been estimated that there may be over 350 million people in the world today who have it. Depression has afflicted humans for as long as records have been kept. Indeed, it was first named as a condition about 2,400 years ago by the famous ancient Greek doctor Hippocrates, who called it ‘melancholia’. It is also worth noting that although we cannot ask animals how they feel, it is likely that they also have the capacity to feel depressed: they can certainly behave as if they do. To a greater or lesser degree, we all have the potential to become depressed, just as we all have the potential to become anxious, to grieve or to fall in love.

Depression is no respecter of status or fortune. Indeed, many famous people throughout history have had it. King Solomon, Abraham Lincoln, Winston Churchill and the Finnish composer Jean Sibelius are well-known examples from history. What is important to remember is that depression is not about human weakness.

What do we mean by ‘depression’?

This is a difficult question to answer, because a lot depends on who you ask. The word itself can be used to describe a type of weather, a fall in the stock market, a hollow in the ground and, of course, our moods. It comes from the Latin *deprimere*, meaning to ‘press down’. The term was first applied to a mood state in the seventeenth century.

If you suffer from depression, one thing you will know is that it is far more than just feeling ‘down’. In fact, depression affects not only how we feel, but how we think about things, our energy levels, our concentration, our sleep, even our interest in sex. Depression has an effect on many aspects of our lives. Let’s look at some of these.

- **Motivation.** Depression affects our motivation to do things. We can feel apathetic and experience a loss of energy and interest, nothing seems worth doing. If we have children, we can lose interest in them and then feel guilty. Each day can be a struggle of having to force ourselves to perform even the smallest of activities. Some depressed people lose interest in things. Others keep their interest but don’t enjoy things when they do them, or are just very tired and lack the energy to do the things they would like to do.
- **Emotions.** People often think that depression is only about low mood or feeling fed-up – and this is certainly part of it. Indeed, the central symptom of depression is called ‘anhedonia’ – derived from the ancient Greek meaning ‘without pleasure’ – and means the **loss of the capacity to experience any pleasure**. Life seems empty; we are joyless. But – and this is an important ‘but’ – although the ability to have positive feelings and emotions is reduced, we can experience an increase in negative emotions, especially anger. We may be churning inside with anger and resentment that we can’t express. We might become extremely irritable, snap at our children and relatives and sometimes even lash out at them. We may then feel guilty about this, and this makes us more depressed. Other very common symptoms are anxiety and fear. When we are depressed, we can feel extremely

vulnerable. Things that we may have done easily before seem frightening, and at times it is difficult to know why. We can suddenly feel anxious at a bus or shop queue or even meeting friends. Anger and anxiety are very much part of depression. Other negative feelings that can increase in depression are sadness, guilt, shame, envy and jealousy.

- **Thinking.** Depression interferes with the way we think in two ways. First, it affects concentration and memory. We find that we can't get our minds to settle on anything. Reading a book or watching television becomes impossible. We don't remember things too well, and we are prone to forget things. However, it is easier to remember negative things than positive things. The second way that depression affects our thoughts is **in the way we think** about ourselves, our future and the world. Very few people who are depressed feel good about themselves. Generally, they tend to see themselves as inferior, flawed, bad or worthless. If you ask a depressed person about their future, they are likely to respond with: 'What future?' The future seems dark, a blank or a never-ending cycle of defeat and losses. Like many strong emotions, depression pushes us to more extreme forms of thinking. Our thoughts become 'all or nothing' – we are either a complete success or an abject failure.
- **Images.** When we are depressed, the imagery we use to describe it tends to be dark. We may talk about being under a dark cloud, in a deep hole or pit, or a dark room. Winston Churchill called his depression his 'black dog'. The imagery of depression is always about darkness, being stuck somewhere and not able to get out. If you were to paint a picture of your depression, it would probably involve dark or harsh colours rather than light, soft ones. Darkness and entrapment are key internal images.
- **Behaviors.** Our behavior changes when we become depressed. We engage in much less positive activity and may withdraw socially and want to hide away. Many of the things we might have enjoyed doing before becoming depressed now seem like an ordeal. Because everything seems to take so much effort, we do much less than we used to. Our behavior towards other people can change, too. We tend to do fewer positive things with others and are more likely to find ourselves in conflict with them. If we become very anxious, we might also start to avoid meeting people or lose our social confidence. Depressed people sometimes become agitated and find it difficult to relax. They feel like trapped animals, restless, pace about and can't sit still, wanting to do something but not knowing what. Sometimes, the desire to escape and run away can be very strong. However, where to go and what to do is unclear. On the other hand, some depressed people become very slowed down. They walk slowly, with a stoop, their thoughts seem stuck, and everything feels 'heavy'.
- **Physiology.** When we are depressed there are many changes in our bodies and brains. There is nothing sinister about this. To say that our brains work differently when we are depressed is really to state the obvious. Indeed, any mental state, be it a happy, sexual, excited, anxious or depressed one, will be associated with physical changes in our brains. Recent research has shown that some of these are related to stress hormones such as cortisol, which indicates that depression involves the body's stress system. Certain brain chemicals, called neurotransmitters, are also affected. Generally, there are fewer of these chemicals in the brain when we are depressed, and this is why some people find benefit from drugs that allow them to build up. The next chapters will explore these more fully. Probably as a result of the physical changes that occur in depression, we can experience a host of other unwanted symptoms. Not only are energy levels affected, so is sleep. You may wake up early, sometimes in the middle of the night or early morning, or you may find it difficult to get to sleep, although some depressed people sleep more. In addition, losing your appetite is quite common and food may start to taste like cardboard, so some depressed people lose weight. Others may eat more and put on weight.
- **Social relationships.** Even though we may try to hide our depression, it almost always affects other people. We are less fun to be with. We can be irritable and find ourselves continually saying no. The key thing here is that this is quite common and has been since humans first felt depressed. We need to acknowledge these feelings and not feel ashamed about them. Feeling ashamed can make us more depressed. There are various reasons why our relationships might suffer. There may be conflicts that we feel unable to sort out. There may be unvoiced resentments. We may feel out of control. Our friends and partners may not understand what has happened to us. Remember the old saying, 'Laugh and the world laughs with you. Cry and you cry alone'? Depression is difficult for others to comprehend at times.
- **Brain states.** A useful way to think of depression, then, is that it is a change in 'brain states'. In this altered state, many things are happening to your energy levels, feelings, thoughts and body rhythms. There are many reasons for this change in brain state that we call depression, and there are many different patterns that are linked to depression, as we will see. But the key thing is to recognize there has been a change in brain state, and your thoughts and feelings are linked to that. It is very important **not to blame yourself** for the difficulties that this depressed brain state makes for you, but rather **work out what will help you shift it** – and that is what we will be exploring in this book.

Are all depressions the same?

The short answer to this is no. There are a number of different types. One that researchers and professionals commonly refer to is called 'major depression'. According to the American Psychiatric Association, one can be said to have major depression if one has at least five of the possible symptoms listed in Table 1.1, which have to be present for at least two weeks.

I have included this list of symptoms here to give you an idea of how some

professionals tend to think about depression. Although a list like the one in Table 1.1 is important to professionals, it does not really capture the variety and complexity of the experience of depression. For example, I would include feelings of being trapped as a common depressed symptom, and many psychologists feel that hopelessness, irritability, and anxiety are also very central to depression.

TABLE 1.1 SYMPTOMS OF DEPRESSION

You must have one of these symptoms:	Low mood
	Marked loss of pleasure
You must have at least four of these symptoms:	Significant change in appetite and a loss of at least 5 per cent normal body weight
	Sleep disturbance
	Agitation or feelings of being slowed down
	Loss of energy or feeling fatigued virtually every day
	Feelings of worthlessness, low self-esteem, tendency to feel guilty
	Loss of the ability to concentrate
	Thoughts of death and suicide

Researchers distinguish between those mental conditions that involve only depression and those that also involve swings into mania. In the manic state, a person can feel enormously energetic, confident and full of their own self-importance, and may have great interest in sex. If the mania is not too severe, they can accomplish a lot. People who have swings into depression and (hypo)mania are often diagnosed as suffering from *bipolar illness* (meaning that they can swing to both poles of mood, high and low). The old term was manic depression. Those who only suffer depression are diagnosed as having *unipolar depression*.

Another distinction that some researchers and professionals make is between *psychotic* and *neurotic* depression. In psychotic depression, the person has various false beliefs called *delusions*. For example, a person without any physical illness might come to believe that he or she has a serious cancer and will shortly die. Some years ago, one of my patients was admitted to hospital because she had been contacting lawyers and undertakers to arrange her will and her funeral as she was sure that she would die before Christmas. She believed that the hospital staff were keeping this important information from her to avoid upsetting her, and she tried to advise her young children on how they should cope without her (causing great distress to the family, of course). Sometimes people with a psychotic illness can develop extreme feelings of guilt. For example, they may be certain in their minds they have caused the Iraq war, or done something terrible. Psychotic depression is obviously a very serious disorder, requiring expert help but, compared with the non-psychotic depressions, it is quite rare.

Another distinction that is sometimes made is between those depressions that seem to come out of the blue and those that are related to life events, e.g., when people become depressed after losing a job, the death of a loved one or the ending of an important relationship. However, in psychotherapy, we often find that, as we get to know a person in depth, what looks like a depression that came out of the blue

actually may have its seeds in childhood.

Clearly some depressions are more serious, deep and debilitating than others. In many cases, depressed people manage to keep going until the depression eventually passes. In more serious depression this is extremely difficult, and getting professional help is important. Depressions can vary in terms of onset, severity, duration and frequency.

- **Onset.** Depression can have an acute onset (i.e. within days or weeks) or come on gradually (over months or years). It can begin at any time, but late adolescence, early adulthood and later life are particularly vulnerable times.
- **Severity.** Symptoms may be mild, moderate or severe.
- **Duration.** Some people will come out of their depression within weeks or months, whereas for others it may last in a fluctuating, chronic form for many years. 'Chronic depression' is said to last longer than two years, and 10–20 per cent of depressed people have it.
- **Frequency.** Some people may only have one episode of depression, whereas others may have many. About 50 per cent of people who have been depressed will have a recurrence.

The fact that depression can recur may seem alarming, but this should really come as no surprise. Suppose, for example, that since a young age you have always felt inferior and worthless. One day this sense of inferiority seems to get the better of you and you feel a complete failure in every aspect of your life. Perhaps a drug will help you to recover from that episode, but even if you become better, you may still retain, deep down, those feelings of failure and inferiority. Drugs do not retrain us or enable us to mature and throw off these underlying beliefs. Therapies are now being developed to help prevent relapses.

How common is depression?

As indicated, depression is, sadly, very common. If we look at what is called major depression, the figures are:

Women (per cent)

24.5% depression at any one time
10.2% at risk

The figures are even higher in some communities (e.g., with poverty). Moreover problems such as eating disorders, drug and alcohol problems and aggressiveness can also be linked to depression, and recede as depression is treated. New research also indicates that rates of and risks for depression have been steadily increasing throughout the twentieth century, but the reasons for this are unclear. Socio-economic changes, the fragmentation of families and communities, the loss of hope in the younger generation – especially the unemployed – and increasing levels of expectations may all be implicated.

In general, then, there are many forms of depression – in fact, so many that the term itself is not so helpful. But it is important to recognize that not all depressions are the same and they can vary greatly in severity and duration.

KEY POINTS

- Depression is very common and has been for thousands of years.
- Depression involves many different symptoms. Emotions such as anger and anxiety are common and at

times more troubling than the low mood itself. People who are depressed may also have a strong desire to escape, for which they may feel guilty.

- There are many different types of depression.
- Some depressions are quite severe, while others are less so but still deeply disturbing and life-crippling.

If you suffer from depression, my key message to you is that if you feel a failure, if you have a lot of anger inside, feel on a short fuse; if you are terrified out of your wits, if you think life is not worth living, if you feel trapped and desperate to escape – whatever your feelings – these reflect your brain state, are not your fault, and millions of others have these feelings too. Of course, knowing this does not make your depression any less painful, but it does mean that there is nothing bad about you because you are in this state of mind. It is a shift in brain state that is painful – depression pulls us into thinking and feeling like this, so these feelings are sadly part of being depressed. True, some people who have not been depressed may not understand it, or may tell you to pull yourself together, but this does not mean that there is anything bad about you. It just means that they find it difficult to understand.

Importantly, there are many things that can be done to help us when we get depressed so a key message is: 'please talk to your family doctor.' There are some helpful (for some people) drugs (antidepressants) available and many effective psychological treatments. We can learn to train our minds to shift us out of depressed brain states. This is covered in Parts II and III.

Causes of depression: How and why it happens

As we saw in Chapter 1, when we are depressed our brains, bodies and minds shift to different patterns of thinking, feeling and behaving. We can call this *a depressed brain or mind state*. A key question, then, is how and why this happens. After all, these depressed states are very unpleasant and don't seem very helpful in our lives. Understanding why our brains can go into depressed patterns is a key research question. In the next few chapters we are going to explore this.

If you're feeling depressed, you may find these chapters tough going at times because they contain *technical* information, and it can be difficult to concentrate when you are depressed. Please don't worry about that. You don't need to read these sections if you don't want to, and even if you do read them it is quite likely that you may only remember one or two key ideas, so there is a summary at the end of each chapter. If you wish, just note those key points and go straight on to Part II, 'Learning How to Cope'. When you feel better, you could return to these chapters, or dip into them. I have expanded them from the first and second editions because depressed people and their relatives often ask to know more about what causes depression. I have also expanded them to explain a new focus on compassion. Being gentle with ourselves will be helpful in our journey out of depression.

How our minds got to be the way they are: old brains and new minds

Old brain and mind – what we share with other animals

It is very easy for us humans to see ourselves as special and different from other animals because we have a certain self-awareness and recently evolved abilities to think, reflect, plan and ruminate – with a kind of 'new mind'. But even though this is true we also have many motives, emotions and social needs in common because of how our brains have evolved and are constructed. For example, animals (e.g., chimpanzees) can become anxious, angry, lustful, vengeful, sad, distressed, agitated or excited, happy, playful, and affectionate. Like us, too, they seek out certain positive things such as food and comforts, and create certain types of relationships. They can fight with each other over status or territory; they can seek each other out for protection, support and friendships; they can form close bonds; they can develop sexual relationships, and can be very attached to their offspring, protecting them, nurturing them and providing for them. Like us, too, they appear to become stressed and depressed if they are socially rejected, defeated or threatened. Indeed, we see

these desires, encounters and relationships going on in their billions in many life forms on this planet every day.

We too are constantly engaging in these behaviors. From the day we are born we seek a loving and caring attachment with our parents. We can struggle for status, recognition and acceptance from other human beings. We want to form relationships with others who care about us and help us. We feel good when relationships go our way. We don't want to be criticized or rejected: then we can get sad, upset or angry. When things go wrong and we feel unable to achieve these desired goals, and/or we feel unloved, or rejected and inferior, our mood can go down, as it can for any other animal.

We can call all these forms of behavior, with their various desires and efforts, *archetypes* because they are forms of feeling and thinking that ripple through many life forms, including us. They give rise to our feelings and desires. Look at this carefully:

We did not create these desires for certain types of relationship and feelings – rather, they are created within us, from our genes and our evolutionary history and are shaped by our life experience.

The point is that we all just find ourselves with this body, with this mind with its varieties of emotions, born into particular families in particular places at particular times – none of which we choose. We sort of 'wake up' through our childhood to the fact of us 'being here' and then try to make the best we can of this strange mind of ours. So, much of what goes on in our minds is not our fault – evolution put these abilities there but, by understanding how our minds work, we can learn how better to cope with unpleasant feelings that can ripple through us, and train our minds to cope. We can influence how our brains are working and steer them towards feelings of well-being and away from depression.

The three emotion systems and their influence on our minds

Let's now look a little closer at how the brain helps us navigate through life, noticing and trying to avoid threats, seeking out things we want, and influencing our feelings in our relationships. The way the brain does this is very complex but we can simplify it in a very useful way. We have special brain systems (networks) that regulate three different types of emotion and action:

- a system that helps detect, track and respond to things that threaten us
- a system that gives rise to desires and feelings of motivation
- a system that helps us feel content, at peace, safe and happy. This system is especially important in social relationships when we feel cared for.¹

These systems are constantly interacting and it is from their interactions that we get 'states of mind'. Figure 2.1 is a diagram of these interacting systems.

Types of Affect Regulation Systems



Figure 2.1 The interaction between our three major emotion regulation systems.

As we become depressed *the balance between these systems changes* and we have far *more* threat-linked feelings of anxiety, irritability, pessimism, shame and anger, far *fewer* feelings of motivation, energy and optimism, and also far *fewer* feelings of contentment, peacefulness and sense of connectedness to other people. It is helpful to understand this in terms of a shift in the balance of feeling and thinking systems. Then we can stand back from the depression and recognize that it is a particular pattern in our brains that we are having to deal with. The reasons these brain systems have become out of balance, or have taken up a new pattern, will be the subject of later chapters.

Thinking about depression in this way gives us an opportunity to think about how we can rebalance the three emotion systems. If you like, we can think about working on ourselves as a kind of *physiotherapy* for our minds. In the second half of this book we will explore how we can rebalance our systems by working on our behaviors, thoughts and feelings. Exercise, diet and medication may also help, but they are not the main focus of this book (see the appendices for some thoughts on these). Next we explore these three emotion regulation systems in more detail.

The threat-protection and safety-seeking system

Life on our planet faces a variety of dangers, from other life forms that want to eat them, fights with others of their own kind, lack of food or shelter, to viruses, bacteria and so on. Because life forms face so many threats, they need to have systems in their brains that can detect them and respond.²

We can call this the *threat-protection and safety-seeking system*, or *threat-protection system* for short. It is designed to detect threats, activate protective emotions such as anxiety and start behaviors that will help us to keep safe, such as running away or avoiding things. In humans and other animals this system can be

activated very quickly, giving rise to feelings of anxiety, anger or disgust, with their associated behaviors for fighting, running away, and trying to get rid of things. Note too that we can have these feelings if we see others – especially those we love – in danger or distress: we want to rush in to protect them.

Although this system was developed for our protection, many of the emotions, feelings and thoughts associated with it can cause us problems and indeed underpin many mental health difficulties. For example, our anxiety or anger can become too easily triggered or too intense, or difficult to turn off. We might become anxious about situations we don't want to be anxious about – such as standing in a queue, going to a party or job interview. Our emotional brain and our logical (new) brain seem to be saying rather different things. When we experience our emotions getting in the way of what we can logically want to do or feel, we tend to see such feelings as 'bad' and 'to be got rid of', but in fact they are only designed as self-protection. It is often because we don't understand that they are part of our alarm and self-protection system that we can have such a negative approach to these emotions. When this happens we tend to fight with them, avoid them or even come to hate them rather than *work with them*.

Our new brains may focus thinking and rumination on threat and losses. The last time I had to take an important exam I found it difficult not to think about it, or to sleep well the night before. That can be useful, of course, because I prepared well (I hope). After the exam I started going back in my mind over what I had written and wondering if I had answered questions correctly or sufficiently, oscillating between confidence and doubt. That is how our minds are, worrying about the future and reflecting on the past. Sometimes focusing on threat and preparing for it is very helpful. However, feeling one's mind constantly pulled to focus on a threat or loss can be very unhelpful. Then we worry and fret about things, and at times we give up trying altogether, anticipating that it will go badly – so we feel there is no point.

Depression as a threat-protection response

Many researchers are now looking at depression from an evolutionary point of view.³ Research has shown that when we are depressed, an area of the brain (called the amygdala) that is associated with detecting and responding to threats seems to become more sensitive.⁴ Indeed, some depressed people can have greatly increased anxiety and/or anger and irritability because the threat system has become 'inflamed', if you like. This may be linked to threat in our current situation, genetic sensitivity, unresolved anger or anxiety issues from the past, or other reasons, but it is useful to think about some aspects of a depression being linked to this *physiological sensitivity* in our threat-protection system. We can then consider how to work on reducing this sensitivity and help to settle it down.

The situations that can trigger depressive changes in our brains are linked to particular difficulties, and we will be looking at these in the next two chapters. Situations that are important to us but where we feel we have lost control, or we feel no matter how much we try we can't reach our goals, or we feel overwhelmed by demands on us, or we find ourselves trapped in situations we don't want to be in (e.g., isolated, or with critical or unkind others), or feeling defeated or exhausted – can all contribute to depression. Feeling isolated, alone, misunderstood, or unlovable and cut off from others is also strongly linked to depression. Depression is a kind of

shutdown, a ‘go to the back of the cave and stay there until things improve’ response.

The feel-good emotions

Depression is not just about having more anxiety and irritability. A key element of depression is that positive emotion systems seemed to be toned down too. We are not able to enjoy things or look forward to things. Things we used to enjoy, such as talking to people, going to parties, planning a holiday or even having sex can become things that are actually unpleasant to do; they fill us with dread and we can see nothing but problems and difficulties in doing them. In fact, although feeling accepted and connected to others is associated with feelings of well-being, when we are depressed we often feel disconnected from other people, as if there is a barrier between us and others, almost as if we are an outsider or an alien. *This tells us that positive emotion systems in our brain are toned down.* So to help us out of depression we have to practise stimulating our positive emotion systems, to get them active in our brains again.

Recent research has shown that there are in fact *two very different types* of positive feeling and emotion systems (see page 17).¹ One type is linked to a system that is activating and energizing; it is the system that gives rise to desires, and the buzz of excitement if something good happens to us or to people we care about, or even if our football team wins. It energizes us. This emotion system helps us to become active, to seek out good things, and to try to achieve and acquire things in life – it gives us certain feelings and drive.

The other positive emotion system is almost the opposite; it’s not about achieving but about being safe and at peace. It is soothing and calming and gives feelings of contentment and well-being. It is the system that people who meditate try to stimulate.

These two systems evolved over millions of years. Let’s look at them a little more closely.

The activating system

This system motivates us to achieve things and do things. It gives rise to our wants, and our desires to satisfy these. When good things happen, we can also get a buzz from this system. For example, if you win the lottery tonight and become a millionaire you may have bursts of excitement and become agitated; your mind will be churning with thoughts of your future; you’ll find it difficult to stop smiling and you may also find it difficult to sleep because your mind will be racing. This is the system that can become overactive in people who have bipolar disorder. But if you are very depressed, even winning the lottery might wash over you because your positive emotion system only gives a slight splutter and you quickly get pulled back into the threat system, dwelling on all the problems having money will bring – how much to give to Uncle Tom and Auntie Betty and what happens if you upset cousin Alfred – what’s the point of money anyway if it makes you feel this bad?

Of course, usually the drive system is not nearly as highly activated as this but it gives us our little bursts of energy and excitement. If we are overstressed or push ourselves too hard, this system can get exhausted, and we can start to lose feelings of motivation and interest in things. We start to feel that we can’t be bothered; even deciding what to have for lunch is boring and we can’t think of anything we fancy.

We find, as the Rolling Stones once wrote, that we ‘can’t get no satisfaction’.

There are many ways in which the drive system can become exhausted. If we overwork and become very tired the system can start to struggle; it runs out of fuel because we’ve been over using it. If we are under a lot of stress for a long time, this again can affect our positive emotion system and we lose energy and motivation. Feeling helpless and out of control can cause the system to become exhausted. If we are being bullied or criticized at home or work, or if we are in a conflict relationship, or if we are very divided on what to do, whether to stay in this job or relationship or leave – these stressors can gradually tone down the drive system.

So when we are depressed it is useful to think about whether this system has become exhausted and, if so, how we can start to heal it, exploring what it needs to get up and running again. If you are self-critical for being depressed or tired, then this is only going to exhaust the drive system even more. Self-criticism does not – under any circumstances – increase enthusiasm, motivation or pleasure. It motivates through threatening and a fear of failure – that is, through your threat system. Sometimes we have to work hard to become more active and put positive things in our lives as best we can. This can mean deliberately training our attention to focus on positive things – things we appreciate, no matter how small – such as the taste of your first cup of tea in the morning, or the smile of a friend. If we recognize that we have a particular problem in a particular system in our brain then we can design a program to get it going again. Taking exercise can help stimulate this system too.

Useful and important as the drive system is, there are signs that Western society is rather overstimulating it and leading us to believe that we can only be happy if we have and achieve things. This leads people to constantly compare themselves with others, to reflect negatively on themselves – and that’s pretty depressing, because it takes away enthusiasm and hope of success. We are also overworking and getting exhausted in the drive for the ‘competitive edge’ or proving ourselves competent.

Contentment, soothing and kindness

How does kindness fit into feelings of depression and a lack of well-being? Well, it does so in some very interesting ways. First, we should note that in our brains we have a system that regulates the experience of ‘having sufficient, enough, and contentment’. When animals are not dealing with threats, and are not having to pursue things like food or other resources, they can be quiet, resting, quiescent and peaceful. We now know that this state is not just about low activity in the threat system. There is a system in our brain that gives us feelings of contentment where we are not seeking or feeling driven to achieve things – we are happy as we are, *right now, in this moment*. Think back to times you might have had feelings of contentment, being satisfied with where you were. People who meditate and become mindful (see Chapter 7) and spend time trying to develop calm states of mind often describe positive feelings of contentment, well-being and peacefulness.

But what has this got to do with kindness? To understand this you need to know that the evolution of our brains and bodies always uses systems that already exist. It is very difficult for evolution to design something totally new. The system that gives us our feelings of peacefulness, calmness and soothing is also linked to affection and being cared for. How did that happen? Simply put, millions of years ago the young of our mammal ancestors that were fed and protected survived and so passed on the

genes for care and protection. Over millions of years these spread throughout the world. Today, whether you look at birds looking after their chicks in the nest, your family dog looking after her pups, monkeys caring for their infants or humans loving their babies, we see the enormous importance of love and affection in the process of protecting and caring. If you look carefully at these interactions you will also see something very interesting. When in close contact with its mother, the young infant is often peaceful and quiet.⁵ An extreme example is the emperor penguin, where the baby chick has to sit on the parent's feet and *not move* or it will freeze.

What do caring relationships do to and for the child? First, they turn off the child's threat system. Indeed, think how a mother is often able to calm and soothe a distressed infant. Through the mother's tone of voice, or cuddling and gentle soothing, the child's brain registers that it is being looked after and this calms the threat system. *This ability to soothe distress with kindness is fundamental to how our brains work.* It is part of our evolutionary design. Our brains are designed to want kindness, and can respond to kindness. And it's not only in child-parent relationships that kindness is powerful. Kindness is one of the most important qualities that people look for in a long-term partner; it's one of the most important qualities people look for in friendship and (along with technical ability of course) one of the most important qualities we look for in our doctors, nurses, teachers and psychotherapists. We may not always be good at giving it, and sometimes we can be grumpy toads – but humans value and look for kindness because their brains are organized to feel more secure and safe in the context of kindness.

To help you think about how kindness operates in the body, consider the following scenario. You are upset about something: maybe a project you were planning hasn't worked out, or you are very disappointed over something, or someone you spoke to was unkind. Imagine you go to a friend, but they are very dismissive or they quickly switch the conversation around to their own difficulties, or are even critical of you and tell you to stop making mountains out of molehills. How will you feel. How will you feel in your body? Think about that. Now imagine you go to a friend who listens very carefully to your story. They sympathize and empathize with your upset, they say how they can understand why you are upset. Maybe they put an arm on your shoulder. How do you feel? You see, you already know in your heart that kindness will have a very different impact on your body. *You have inner wisdom on the value of kindness* and can learn to tune into it rather than getting caught up in the angers, frustrations, disappointment and fears of your threat system. As we will see in a moment, this is also the case for our own self-focused thoughts and attitudes to ourselves – these too can be rather bullying, but we can train them to be kind and supportive.

Kindness is important, too, because it underpins trust. When we trust people we are no longer orientated by threat, nor are we striving to impress them. We can turn to them if we need to. In a way kindness and trust can also tone down aspects of our drive and threat-protection systems and bring them more into balance. This is important to understand, because sometimes people who are vulnerable to depression feel they have to drive themselves hard, to impress others or to be liked and accepted. The drive system gets out of balance because of feeling insecure with other people, which means that the soothing system requires some development. We will be looking at exercises to help you with this later.

Without going into too much detail, these kinds of emotions use different

chemicals in our brains, in different patterns to those of excitement and achievements.¹ These calm, good feelings of well-being are linked to endorphins (the body's natural opiates) and a hormone called oxytocin. This hormone has generated a lot of interest recently because it is linked to feelings of closeness and trust with other people, and the warm feelings we get from affiliation and affection.⁵

Problems with our new minds

Our thoughts can also affect how these systems work and balance each other. Over the past two million years or so the human brain has been evolving abilities to think, to imagine, to predict, to ruminate and plan. We can form mental images in our minds. We can imagine the future, and think about how we can create a future that we want (or feel trapped in one we don't want). Much of our life is spent thinking about and planning for our wants; generating hopes, planning for our future, developing goals and worrying about obstacles and setbacks. Animals simply live out their lives, but humans are life planners and try to live according to their plans. This thinking gets pretty sophisticated. Indeed, it is because we can think like this that we have an intelligence that underpins science and technology. Our ability to imagine, think and plan with some complexity is central to the *human* mind.

As we will see later though, *what* we focus and think about, and how we focus our attention and thinking, can seriously affect our moods. Monkeys don't worry about being able to pay the mortgage, or failing a job interview, nor how to get out of a marriage; nor do they ruminate about feeling depressed in the future. Humans clearly do, though, and this can be one reason for low mood.

We also have a complex language, can talk to each other and can share wonderful ideas and feelings. We can share and build our plans and goals together. We can use symbols that help us to think. We have also evolved a *sense of self-awareness*. We have an awareness of being 'alive', being a self with a consciousness. These are wonderful abilities and give rise to our science, art and culture. We create and follow fashion because we have a sense of ourselves and how we wish to appear to others. We can create a sense of self-identity and this varies according to where we live. Think how different our self-identity would be if we grew up in a Buddhist monastery, in the backwoods of Alaska, in glitzy Hollywood or in a poor inner-city area.

However, there is a *downside* to these wonderful new mind abilities, because if our thinking about ourselves or future becomes overly threat- or loss-focused then we can lock ourselves into threat-process thinking and some very unpleasant feelings indeed.

How our thoughts and imaginations affect our brains

To help you explore how thoughts, images and memories can have powerful effects on systems in our brains, look at the brain depicted in Figure 2.2. It demonstrates how external things and *our imagination* of external things can work in a very similar way. Let's start by using examples that I commonly use and have discussed on my CD *Overcoming Depression: Talks With Your Therapist*.

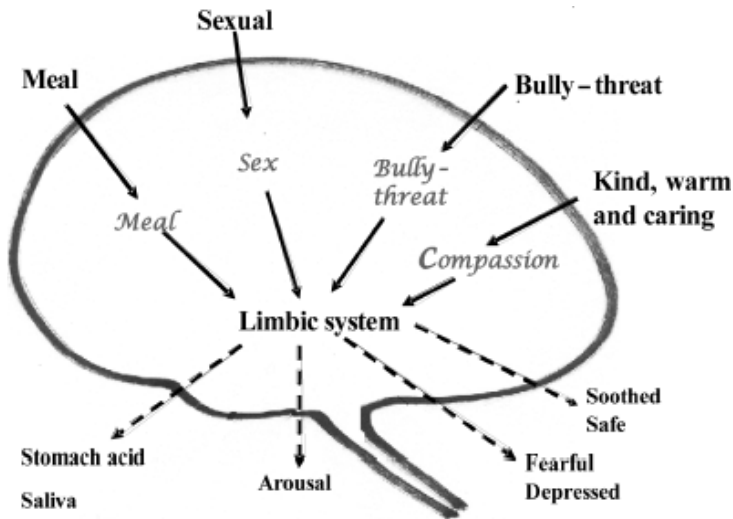


Figure 2.2 The way our thoughts and images affect our brains and bodies.

Imagine that you are very hungry and you see a lovely meal set out on a table. What happens in your body? The sight of the meal stimulates an area of your brain that sends messages to your body so that your mouth starts to water and your stomach acids get going. Spend a moment really thinking about that. Now suppose that you're very hungry but there isn't any food in the house, so you close your eyes and *imagine* a wonderful meal. What happens in your body then? Again, spend a moment really thinking about that. Well, those images *that you deliberately create in your mind* can also send messages to parts of your brain that send messages to your body, so again your mouth will water and your stomach acids will get going. Remember though, this time there is no meal: it's only an image that you've created in your mind, yet that image is capable of stimulating those physiological systems in your body that make your saliva flow. Take a moment to think about that.

Here's another example, something that some of us have come across: you see something sexy on TV. This may stimulate an area of your brain that affects your body, leading to arousal. But equally, of course, we know that even if you're alone in the house you can imagine something sexy and that can affect your body. The reason for this is that the image alone can stimulate physiological systems in your brain in an area called the *pituitary*, which will release hormones into your body.

The point is that thoughts and images are very powerful ways of stimulating reactions in our brain and our body. Take a moment and really think about that, because this insight will link to other ideas to come. Images that you deliberately create in your mind and your thinking will stimulate your physiology and body systems.

Let's consider a more depression-linked example. Suppose someone is bullying you. They are always pointing out your mistakes or dwelling on things you are unhappy with, or telling you that you are no good and there is no point in you trying anything, or being angry with you. This will affect your threat-protection and stress systems. How do you feel if people criticize you? How does it feel in your body?

Spend a moment thinking about this. Their unpleasantness will make you feel anxious, upset and unhappy because the threat emotion systems in your brain have been triggered. If the criticism is harsh and constant, it may make you feel depressed. You probably would not be surprised by that. However, as we have suggested, and here is the point – *our own thoughts and images can do the same*. If you are constantly putting yourself down this can also activate your stress systems and trigger the emotional systems in your brain that lead to feeling anxious, angry and down. That's right – our own thoughts can affect parts of our brain that give rise to more *stressful and unpleasant feelings*. They can certainly tone down positive feelings. Who ever had a feeling of joy, happiness, contentment or well-being from being criticized? If we develop a self-critical style then we are constantly stimulating our threat system and will understandably feel constantly under threat. Self-criticism then stimulates the threat system. This is no different from saying that sexual thoughts and feelings will stimulate your sexual system, and the thoughts of a lovely meal will stimulate your digestive system.

There are many reasons for becoming self-critical. One common reason is that others have been critical of us in the past and we simply accept their views as accurate. We don't stop to think whether they were genuinely interested in our welfare and really cared and wanted to help us – in fact they may just have been rather stressed and irritable people who were critical of everyone. We have gone along with their criticisms of us – as one often does as a child – and never stopped to think if they are accurate or reasonable. Or it may be that we are trying very hard to reach a certain standard, or to achieve something, or present ourselves in a certain way. When it doesn't work out as we would like, this can frighten us because we may think we have let ourselves down or *other people will reject us*. In our frustration we then criticize ourselves and take our frustration out on ourselves. All very understandable, but not helpful, because we are giving ourselves negative signals that *affect our brains*. Research on what happens in people's brains when they are self-critical confirms that it really is the case that we stimulate threat systems in our brain. The more self-critical we are, the more those systems are stimulated. Learning to spot self-criticism and what to do about it is a key issue in later chapters.

The power of self-kindness

We have spent some time looking at the three emotion regulation systems and we explored a system in the brain that helps to soothe and calm us when things are hard or we are frightened. We feel soothed when other people are kind and understanding, supportive and encouraging. We have a system in our brains that can respond to those behaviors from others. Suppose that when you are struggling there is someone who cares about you, understands how hard it is, and encourages you with warmth and genuine care – how does that feel? Maybe you could spend some time thinking about this right now. Or imagine that you are learning a new skill and finding it hard; maybe other people seem to be getting the hang of it more easily than you. However, you have a teacher who is very gentle and warm, pays careful attention to where your difficulties are, helps you see what you are doing right and how you can build on those good things. Compare this with a teacher who is clearly irritated by you, makes you feel you're holding up the class, and focuses on your deficits. Most of us are going to prefer the first type of teacher, and indeed will do much better.

So using exactly the same idea as imagining how a meal can stimulate sensations and feelings in our bodies linked to eating, we can think about how our own thoughts and images might be able to stimulate the kindness and soothing system. If we can learn to be kind and supportive – to send ourselves helpful messages when things are hard for us – we are more likely to stimulate those parts of our brain that respond to kindness. This will help us cope with stress and setbacks. As this book unfolds, you will learn how to engage with compassionate attending, thinking, behavior, imagery and feeling (see Chapter 9). Bear in mind all the time that this is about helping you to re-balance systems in your brain.

What happens in our brains when we focus on self-critical or self-reassuring and self-compassionate feelings? Self-criticism stimulates parts of our brain linked to threat, whereas self-compassion and reassurance stimulates parts of our brain linked to empathy and soothing. However, there is an added complication. For some people who are very self-critical, starting to become self-compassionate can seem like a threat. Some people feel that wanting kindness, or even making an effort to be kind and gentle to oneself, is a weakness or an indulgence. They believe that either they or others simply don't deserve it. Our research indicates that when people first start to be kind to themselves, they can feel it as rather strange or threatening. They have to work through these 'fears' to start training their minds in self-kindness.

Nonetheless, there is now a lot of evidence that being compassionate or kind to yourself is associated with well-being and being able to cope with life stresses. You can read more about this from a leading researcher at www.self-compassion.org.

There are important differences between self-compassion and self-esteem. For example, self-compassion is important when things are difficult or going wrong, and you are having a hard time. Self-esteem, on the other hand, tends to be associated with doing well and achieving. Self-esteem is more linked to our drive-achievement system. It often focuses on how well we are doing in comparison with others, and this is why low self-esteem is often linked to feeling inferior – as we are judging ourselves in comparison with others. Self-compassion, on the other hand, is about focusing on our similarity and shared humanity with others, who also struggle as we do.

Our brains have been designed by evolution to need and to respond positively to kindness, so it is not a question of 'what we deserve'. It is not self-indulgence, any more than training your body to be fit and healthy is a self-indulgence. It is simple a question of treating our brain wisely and feeding it appropriately. This is really no different from (say) understanding that our body needs certain vitamins and a balanced diet. It's not a question of whether you deserve to give your body vitamins or not, you simply do it because it's sensible. It's the same with kindness. It's not an issue of deserving, it's an issue of understanding how our mind works and then practising how to feed it things to help it work optimally. We will be looking at this as we go through the book because some people find this a bit tricky; they can even be frightened to give up their sense of being inadequate or bad in some way. However, they can practise switching to self-kindness each day and see how things go.

Not our fault

I'm sorry if I seem a bit repetitive here, but this is an important idea to convey:

‘depression is not our fault and there is nothing bad about us’. Indeed, evolution may have designed depression (with its reduced positive feelings and increased negative feelings) as a kind of protection when we are in a high-stress environment – like a safety switch or fuse on an electrical circuit that trips out if it is overloaded. The reason for hammering away at this idea is because some depressed people struggle terribly, feeling responsible, inferior or inadequate in some way for being exhausted or depressed. That’s why so many depressed people don’t seek help – because they are ashamed of depression. They may not even recognize it themselves.

If you can take the approach outlined here, you can see that our depressions need our compassionate understanding – to be worked with, worked on and healed as best we can. We did not design any of the mechanisms in our brain that give rise to depression – nor any of the desires that may be thwarted, and cause depression – nor the genes that might make us vulnerable to depression – nor the early life experiences that also make us vulnerable to depression. If we see this, then we also see that depression cannot possibly be our fault.

However, because the depression is happening inside our heads the question is, how can we take responsibility or be ‘*response able*’ – that is, come up with healing and balancing responses to our depressed brain states? Can we learn to settle down our threat-protection systems? The moment we give up self-blaming and shaming, refuse to see depression as a personal weakness or even be frightened of it (but instead see it as a brain state pattern that has been created in us), we can turn around and face it and do what we can to overcome it. Seeing that the basis of our depression is not our fault is not to say that we aren’t doing things that are making the situation worse, or that we couldn’t help ourselves more than we are. Indeed, we may need to take *more responsibility* for changing our behaviors, our thoughts or even styles of relating, and work our way out of depression.

The need for kindness

We are going to be looking at many ways that we can tackle depression throughout this book, but there is a key message that I want to convey: whether you work with your thoughts or feelings or your behaviors, if you learn to do it in the spirit of support, encouragement and kindness, this will give you an extra boost to your efforts. Indeed, kindness to yourself may be one of the things that you haven’t been too good at, and one of the skills that require practice. Some of you will be frightened of that idea; you may see self-kindness as an indulgence or weakness or letting yourself off the hook, or you don’t deserve it, or you might feel that if you’re kind to yourself and enjoy life something bad will happen tomorrow; you’ve always got to pay for the good times. Or it may touch sadness in you because it reminds you that you’ve been yearning for kindness and connectedness for a long time. If you are feeling or thinking this, you are certainly not alone! Many depressed people have these types of beliefs and fears. So we are going to work a step at a time. But as I have suggested, think about self-kindness in a different way. Take a physiotherapy approach to your brain and think about exercising/training it – a kind of emotional fitness training. Self-kindness is a way to restart that soothing system and bring balance to your mind.

KEY POINTS

- Our brain has been built and designed over many millions of years through a process of evolution.
- In our brains today are actually two types of mind. One is the emotional mind, which we share with other animals, that can spring into action quickly with (for example) anxiety and anger. The other is the thinking, imagining, fantasizing mind that can increase or dampen our emotions.
- To help guide us through life we have three different types of emotion system in our brain:
 - a threat-protection system that helps detect, track and respond to things that threaten us
 - a drive system that gives rise to desire and feelings of motivation
 - a soothing system that helps us feel content, at peace, safe and happy. This system is especially important in social relationships when we feel cared for.
- Our thinking and imagining can stimulate any of these three emotion systems. When we focus on threats, interpret situations as threatening or loss-filled or ruminate on threats and losses, we tend to stimulate the threat-protection system. When we focus on achieving and attending to our efforts we are more likely to stimulate the drive system. When we focus on contentment and kindness we tend to stimulate our soothing system.
- This knowledge allows us to take more control of which systems we will stimulate through our thinking, imagination and rumination. We can learn to how to adjust our thinking and behavior, and engage in various exercises for our minds, which can bring these emotion systems more into balance and counteract depressed brain states.

How to do this is the subject of Parts II–IV of this book.

How evolution may have shaped our minds for depression

In this chapter we're going to look at the possible *functions* of depression, or the purpose behind it. By doing this we can understand that depression is not (just) about an illness or some pathology, but evolution has actually made it possible for our brain to create these states, and we can think about why that is the case.

Emotions and their uses

Let's start by thinking about the functions of our emotions in general. Different emotions evolved because they help us to see and react to the environment in different ways.¹ Emotions *guide* us (and other animals) towards certain important goals, such as developing relationships, or avoiding harm, or overcoming obstacles. Our emotions make things matter to us. If you didn't have feelings about things, would anything really matter to you? Let's look at some emotions related to our threat-protection system. As we look at each emotion think carefully about how they are part of self-protection. They are not designed to give us a hard time but actually to help us.

- **Anger** can be triggered when we are frustrated, or something we want is blocked, or we see an injustice, or if someone puts us down. Anger makes us want to approach the problem, do something about it, 'sort it out'. Anger can also make us want to retaliate against another person who has upset us or someone we love. When anger gets going, our bodies 'feel' a certain kind of way, our minds focus on things that annoy us. We have certain types of thoughts that go with anger; think about your own thoughts when you become angry. There will probably be particular things in your life that trigger anger for you; we all have our buttons that can be pushed. Notice how anger pulls your thinking in certain ways – almost like a whirlpool.
- **Anxiety** is focused on threats; it gives us a sense of urgency, prompting us to do something. Anxiety can make us want to run away and keep ourselves safe and out of harm's way. When anxiety gets going, it pulls our thinking to focus on dangers and threats. Again, like anger, there will probably be certain things in your life that tend to make you anxious.
- **Disgust** makes us want to expel noxious substances or turn away from them. Disgust feels different from anxiety and anger. It was originally designed to keep us away from poisonous substances, and is commonly believed to be linked to bodily things. When disgust blends with anger, we can have **contempt**.
- **Shame** is usually a blend of other emotions of anger, anxiety, and disgust. It is an emotion that is specifically linked to a sense of ourselves. Typically, shame makes us want to run away, or close down and be submissive, to avoid rejection. We can have a sense of shame if we think others look down on us.
- **Guilt** makes us wary of exploiting or harming others, and prompts us to try to repair the relationship if we do. We will be looking at shame and guilt in later chapters.
What about positive emotions? What functions do they have?²
- **Excitement** is an emotion that is energizing and directs us towards certain things. We generally feel excited about something we want to do or achieve. We can also have a buzz of pleasure when we do achieve. Positive emotions direct us to things that are helpful to us. We can also get small feelings of pleasure from simple things such as enjoying a meal, or the sun of a warm day, or going for a walk, or talking to a friend.
- **Contentment** is a very different positive emotion to that of excitement. It gives us a sense of being at peace and of well-being. Contentment helps us to stop driving ourselves and 'wanting' all the time. This allows us to rest.

Interestingly, it's not an emotion that Western societies focus on very much, but it is key to well-being.

- **Love and affection** are emotions that indicate positive relationships between people and tell our brain that we are safe and tone down the threat system. The feelings help us build bonds, and think about each other when we are not currently in sight. As we noted in the last chapter, affection can have very soothing qualities.

Think of each emotion in this list and ask yourself: 'What does my body want to do if this emotion is aroused in me? How does emotion direct my thinking? How does my thinking differ if I'm angry or anxious or in love?' The \$64,000 question here is: are you thinking about your emotions, or are your emotions thinking for you? The honest answer can be both, but note that we often get caught up in an emotion and the emotion directs our thinking. Sometimes we haven't learned how to stand back and not get caught up in the whirlpool and dragged into the emotion. The emotion says 'think this', 'dwell on this', 'fret about that' – and we simply do. But of course it is a two-way street. How we think about things, the interpretations and meanings we put on things that happen to us, can also stir our emotions.

Emotions, then, have certain functions, even if they are unpleasant and painful to us. We sometimes call threat self-protective emotions (of anxiety or anger) *negative* or *bad*. However, this puts us in the wrong frame of mind for dealing with them. They are not negative emotions simply because they feel bad: they are part of our self-protection system and once we start to befriend them we will find they are easier to deal with. Or put it this way – *there are many good reasons for feeling bad*. Imagine what a person would be like who did not have the capacity to feel anger, fear, disgust or guilt. These emotions are part of our being; they have evolved as part of our human nature. We can suffer various painful states of mind because we have normal, innate potentials to switch into them.

We live in a world that stresses the importance of happiness and feeling good. The problem is, you can be led astray by some of these claims because they don't also tell you that feeling bad is at times a normal, indeed important, part of life – and can be good for you in the long term. Anxiety about failing your exam may make you study hard, or anxiety about certain areas of the town you live in will keep you away from there.

Consider too that if someone we love dies, we can find ourselves in a deep state of grief. And very unpleasant it is too, with its associated sleep problems, crying, pining, anger and feelings of emptiness. We may have learned to share these feelings or to keep a stiff upper lip, but there is, in most of us, a potential grief state of mind. As another example, we all have the potential for aggressive, vengeful fantasies and attitudes: if someone harmed your child, your inner desire for revenge could be intense. Also, of course, we all have the potential for feeling anxious. All these possible feeling states are in our genetic blueprint. There are genetic and developmental differences among us that affect how easily or intensely these emotions can be triggered in each one of us.

Our potentials need to be triggered

We can have innate potentials for many negative (and positive) emotions but never (fully) activate them. Suppose nobody you love dies before you do? In that case you might never have an occasion for profound grief, and even though you almost certainly have the innate capacity to experience grief, you may never actually feel it. If no one does you or your family serious wrong, you may never experience the

urgent and repetitive nature of vengeful thoughts and feelings. The fact that many people don't suffer certain states of mind (e.g., grief, sadistic vengefulness, depression) does not mean they do not have some capacity for them.

We can look at the helpfulness of emotions in terms of four aspects: what *triggers* the emotion, how *intense* the emotion is, how *long it lasts* and how *frequently* we experience it. There are many factors that can influence each of these four domains, so we can train our mind to work on each aspect of a difficult emotion.

One of the most important aspects of our compassionate, evolutionary approach is therefore to recognize when emotions are helpful, and when they have taken a life of their own, or when our thoughts or style of interpreting things keep us living in the shadows. Emotional systems themselves can rather overpower and 'take control' of our thoughts and sense of self. I'm sure we have all had the experience of being anxious or angry, and knowing in our hearts that we are probably letting our emotions run away with us, but without practice it's sometimes difficult to rein them back.

So what's the point of depression?

However, you may well ask, what is the point of depression?³ The adaptive value of anger, anxiety and love is easy to see, but depression seems so unhelpful. Well, to be frank, it often is. Now one way to think about this is in terms of balance. For example, a certain level of anger can be helpful but intense anger and aggression often aren't. Anxiety can be helpful, but intense panics usually aren't. Although we have a basic anxiety and anger system, for a whole number of reasons these emotions can get out of balance and become too intense, too easily triggered, and last too long.

The first thing to recognize is that depression is partly linked to old brain systems. This is why animals can go into depression-like states, and scientists study those states in animals to understand depression better. We know depression is about toning down positive emotions and toning up threat-focused ones. Our key question is: *under what conditions might it have been useful for animals to lose confidence, be less positive, become more threat sensitive, and become less active in their environments? When might it have been useful to have a 'go to the back of the cave and stay there until it's safe' brain state?*

When we pose the question in this way we search for answers quite differently than if we assume depression is simply 'a disease'. You may already have some answers forming in your mind about when it is useful to tone down positive emotions and tone up negative ones. In fact it turns out that there are a number of conditions that can trigger these brain state patterns in animals.³ One is loss of close attachments, particularly in the young, another is social isolation, another is conflict, bullying and defeat, another is helplessness over major stressors, and another is entrapment. When you think about it, there are many situations where we can see a toning down of positive emotions and a toning up of negative ones. In all these situations, the brain will automatically shift into patterns of toning down positive emotions and toning up negative ones.

We can get further insight into this by looking at what the new brain's abilities for thinking and self-awareness makes of our depression. How do depressed people see our world – what do our minds focus on when we are depressed? Is it love or the

loss/lack of love? Is it winning or losing and feeling defeated? Is it harmony or conflict? Is it freedom or entrapment? Is it control or feeling out of control? Well, of course, it is usually the latter in each case. We know that depressed people often lose energy and give up on things; they see themselves as inferior, even worthless; they lose confidence and behave submissively rather than assertively. Just as we can ask, 'When was it useful to get anxious or angry?' we can ask, 'When might it have been useful for our ancestors to give up on things, to see themselves as inferior and to behave submissively?' There are a few answers.

Stopping us from chasing rainbows

Many people believe it is important for us to follow our dreams; to have clear goals and go after them. There is a lot of wisdom in this. Indeed, being able to decide on goals, the kinds of things you want in life, and committing yourself to try and achieve them is helpful. However, we all know that on this path we will have to cope with disappointments and setbacks, losses and failures. Sometimes we might even need to recognize that the thing we so dearly want is actually out of our reach and we have to change direction. We come to realize that our expectations are too high, we have been chasing rainbows and running to the horizon. This can be hard to acknowledge, and sometimes it's very difficult to let go.

One view of the value of mild depression, for us and other animals (and keep in mind throughout this section that by depression, we are talking about 'toned down positive emotions and toned up threat-focused emotions'), is that it helps us to give up aspirations that we are unlikely to fulfil or achieve.⁴ Supposing you want a bigger house or a better car. You work hard for the money, but you just can't get enough. At some point your energy and enthusiasm begin to wane and eventually you give up and switch to another possibility; you have to tone down your aspiration. Without any internal signal that could prompt us to give up pursuing the unobtainable, we could well continue to pursue it and so waste a lot of time and energy and end up with nothing. Low mood is a 'give it up' signal from old brain systems. Feelings of frustration and low mood can be automatic. At times we have to learn when to override them and keep going or listen to them and make changes in our lives.

Whether the mood is a mild dip or a more serious depression may depend on whether we are able to accept giving up and come to terms with our loss, or whether we keep pursuing the unobtainable and failing. It may also depend on how our new brain, with its thinking, ruminative and self-aware abilities, deals with this loss. If we see having to give up as due to a personal failure, or rejection in some way, this will tone positive emotion systems down even further. You have probably seen this yourself. People who are able to come to terms quickly with having to give up on things and losses, and are able to move on, are less vulnerable to depression than those who struggle to let go, who ruminate, remain frustrated or angry, self-blame, and so forth.

Consider David, who is trying to date Helen. He has strong feelings and desires for her. Over a few months, he builds fantasies and dreams about how great it will be if they can get the relationship working and he tries various things to woo her. Then she agrees to a first date, but at the end of the first date, Helen says, 'Thank you, I've had a lovely time but I don't want to make it a long-term relationship; so it's a one-off for me.'

It is normal and natural for David to have a dip in mood in response to this disappointment and setback, because it's the end of his striving, plans, fantasies (that gave good feelings) and hopes. He must now live in a world where those fantasies and desires are not going to happen. Not only has he lost the possibility of the future he wanted with Helen, but also it is the end of the fantasies that gave him good feelings and stimulated his excitement system. Consider what David would need to do to get depressed about this. What would he think about and dwell on? And now, in contrast, consider what he could do to get over this sad but not uncommon event as soon as possible and move on.

Interestingly, we know that some depressed people don't know how to tolerate and accept painful feelings, how to think and behave, to move on from major life setbacks. They can get stuck, in various ways. They tell themselves that feeling the pain of setbacks and disappointments is awful and unbearable, and are desperate to escape from those feelings, rather than learn how to 'be with them and work through them'. Or they may be angry and demand that life shouldn't be like this – when clearly life is often unfair and harsh. Sometimes people go in for self-blame or ruminating, hoping this will help them find a way to control things in the future. For some a loss might bring back painful memories of previous rejections, perhaps from childhood, and feeling unlovable. David might even make this sad situation worse. He might start to phone Helen up, trying to change her mind; or he might become unhappy and try to woo her by making her feel guilty. He might tell her he is drinking, or even that he is now depressed. There are many ways he could behave that will actually turn Helen's positive feelings for him quite negative. She would then reject him more harshly, which will then hurt him more, which would then feed into his feelings that he is unlovable, or other people are uncaring. David probably won't recognize that his own behavior is part of the problem here.

The point is that we can't avoid the pain of life, and dips in mood are normal reactions to major setbacks. Learning tolerance and acceptance of life's pain is at times the way forward. What we can do is learn how to treat ourselves kindly and compassionately to get through these difficult waters. We can also learn how to let go gently, and this means coming to terms with grief as part of life.

Reactions to loss: depression and grief

Coming to terms with not being able to be as we wish, or have what we want, or the relationships we want, is about grieving and our ability to allow ourselves to grieve. It has been suggested that some forms of depression are like grief. Grief can have a social and a non-social aspect. For example, think of the footballer with a promising international career who damages his knee and can no longer play. Sickness, illness (including mental illness) and injury are common reasons for changing the course of one's life and can require a lot of adjustment and grief work. We are confronted with grief for the loss of the person we wanted to be or hoped to become. As for David above, these losses also involve the loss of a fantasy life, the loss of how we would enjoy imagining, planning and thinking about how we were *going to be*, how life was going to be, what we would be part of.

Loss of feelings of connectedness

Responding to the loss of a loved one with pining, anger, anxiety, sadness, loss of

positive feelings and motivation is the way our threat-protection systems respond to important losses. Many young animals, including rat pups, baby monkeys and human infants, can show what we call a ‘protest–despair’ response to separation from, or loss of, the mother or those they have affectionate bonds with. Commonly, at first the infant *protests* and becomes more active (restless, angry and anxious, and in humans tearful) but if the mother does not return the infant becomes quiet and withdrawn. This condition has been called a *despair state*. What on earth could be the value of such a display or state? Keep in mind that this is toning down of positive emotions and toning up threat-protection. For juveniles in the wild, who are unprotected by a parent, it is important that they don’t move around too much, get lost, get dehydrated in the sun, or that their crying and obvious distress attract the attention of predators. The way evolution designed this was to create a potential brain pattern that would tone down positive emotion and tone up negative emotion. The infant will go into a very anxious and vigilant state, which urges it to hide away.

We think that something like this brain state and pattern can be triggered in depression, because the depressed person often feels as if they are disconnected from others, alone and lonely, cut off, and, without a sense of connectedness, the world feels dangerous to them. The ‘go to the back of the cave strategy’ switches in and they lose energy, confidence and motivation to go into the world.

The mechanisms for coping with loss, which have evolved over millions of years, seem to be the rough blueprint for many of our human responses to serious personal losses. We too can go through a protest stage of feeling angry and looking for the loved one, followed by numbness and despair. Of course, most grief in humans is complex, and people can move back and forth through several phases, so I do not mean to oversimplify it, only to indicate that there are evolved mechanisms at work. ‘Attachment losses’ are painful and stressful because we are biologically set up for them to be so. Having these feelings arise in us is not our fault – but we need to think how we can help and heal them.

In some depressions the protest–despair mechanism works in very subtle ways. It is as if there is a continuous background sense of not really feeling close enough or connected enough to others, and yet desperately wanting to. Sometimes depressed people will say they have a background feeling of always ‘feeling alone and disconnected from others’. Sometimes people become depressed even though they have not *recently* experienced any actual major loss, but in the course of therapy it may turn out that they have never felt loved or wanted by their parents or partners, and are in a kind of grieving–yearning state for the closeness they lack.

Loss of our ideal other

There are always two types of parent in our heads: the one that we had, and the one that we wanted. If these are too far apart, people can experience conflicts over the one they actually had (warts and all) – and desires for the one they wanted (protecting, affectionate and understanding). If we had difficult relationships with parents, it is easy to forget that sometimes we may need to grieve for the parent we so wanted and never had, and work out how to deal with those feelings. One depressed woman, when considering this, acknowledged that she had never really allowed herself to think about the kind of mother she had wanted, because she had felt disloyal to her own (angry and depressed) mother. However, giving herself

permission to think about this allowed her to grieve for the mother she had wanted. This helped her to 'feel more at peace within myself and give up trying to pretend or hope that my mother could be anything other than she is. She can never be as I want her to be.'

Some people want to be close to others, but in their early family life have experienced closeness as associated with punishments or threats, or as something withheld or not available. Thus we can have a deep yearning for closeness with others (it's part of our nature) but also a basic belief that we are unlovable and/or that other people are unreliable and will severely disappoint or hurt us. The depression has to do with our being in a state of wanting closeness but being unable or frightened to get it.

How we relate to others in close relationships

Relationships are major arenas for depression because so many of our desires and wants focus on them. Relationships can stimulate excitement-drive and pleasure centres and also soothing, contentment and well-being centres in our brains. This does not mean you can't be happy without a relationship – many people are, and in fact many people today are choosing not to engage in intimate relationships but enjoy the single lifestyle.

Some people experience what is called *anxious attachment*. They are frightened of being rejected or abandoned; they become anxious if left on their own and angry at separations. In contrast, other people may decide that attachments to others are too painful and difficult, and so they *avoid* closeness. Others move between anxious and avoidance styles: sometimes they seem to want a lot of closeness and reassurance that they are loved (and lovable), but at other times they are aloof and distant. This style can be difficult for partners, who can't always make sense of the person who needs closeness today but wants to escape tomorrow, so (stressful) conflicts can arise. All of us can have these various relating styles to varying degrees, and stress can affect them. For example, when we are under stress, we may want more reassurance and closeness from our loved ones; but when our jobs and lives are going well, and we feel good, we may want less closeness and more freedom to come and go. Lonely, 'despair-type' depressions can arise when it seems that we cannot get close enough to others; we feel cut off from others. When people are depressed they often feel emotionally alone and isolated; *this is commonly part of the depressive experience*. It can feel as if there is a barrier between oneself and others.

However, depression can also arise from *too much closeness*. We may feel trapped and weighed down in relationships and can't get away, or don't have enough space or distance from others. Relationships can feel suffocating. We might feel guilty about even wanting to get more space. Too much *and* too little closeness can cause stress linked to depression.

Helping us cope with defeats and hostile places

Another evolutionary approach looks at why some depressed states are associated with feeling *inferior to others*, *subordinated* and *defeated*. The 'stop pursuing rainbows' and grief models described above do not really tell us why depressed people would feel inferior or defeated. We need to consider the fact that depression can make us give up attempting all sorts of challenges and reduces our aspirations; it

knocks out our optimism and ‘go for it’ attitude; it can leave us with feelings of inferiority and shame. How could this have been adaptive?

According to this approach, there are biological differences between animals who have high rank and those who have low rank. It is now known that animals that have been subordinated or have suffered a lot of attacks from others show behavioral and biological changes similar to those in depressed humans. In some very subordinate animals the stress systems are in overdrive. Some of this stress is caused by the harassment of subordinates by higher-ranking animals, but there is another aspect to it. It might not be a good idea for a very subordinate animal to stroll around as if it were powerful, competent and dominant; to do so will only invite fights that it will lose, probably being injured in the process. It is in the subordinate’s interest to keep a low profile, not be ambitious, and to look out for trouble. Toning down positive systems and toning up threat-focused ones is one way the brain enables a subordinate animal to protect itself, stay out of trouble and be socially on guard.

Some depressions, then, may be related to potential states of mind that can be triggered by certain no-win situations and/or where there is *enforced subordination* (feeling you have to do things you don’t want to, often because of fear; feeling that others have some power or control over you). This is a kind of ‘stay low’ mechanism. This may be a reason why depressed people often feel inferior, worthless, and at the bottom of the pile (like a low-ranking animal) and find it difficult to be assertive.

Subordinate thinking

‘Subordinate thinking’ or ‘thinking of oneself as inferior and subordinate’ is very much a part of how many depressed people think about themselves. Depressed people may label or judge themselves and/or feel judged by others in ways that are not only negative but also suggest they have been allocated a low rank or status. In extreme cases, they might actually feel ostracized and excluded by other people. Judgements such as ‘inferior’, ‘unlovable’, ‘worthless’, ‘bad’, ‘inadequate’, ‘useless’ and so on are, in effect, assignments of status that give the individual a low rank in the social order.

Mood, then, is partly an energy control system that signals status and confidence. The better our (drive-linked) mood, the more confident we feel and the more we seek out those things that are important: friends, sexual partners, good employment, and so on.² Like our primate cousins, the more confidence we feel the more we stand tall and display that confidence. As our mood goes down, our confidence slips away as if we are becoming subordinate in a potentially hostile or rejecting world, and we take a low profile. Indeed, depressed people often don’t stand tall but tend to slouch with head down and eyes averted. We may put on a front, but as our mood drops further this deception is harder to keep up; we lose enthusiasm for trying to ‘go for it’ and want more and more to get out of the way and hide.

Of course, if we are happy being subordinate (and in fact we often are, so long as those above us are nice to us, and we feel the ‘higher ranks’ will help us rather than look down on us) then being subordinate is not stressful at all. Letting others take the strain can be a good choice. The kind of subordination that is stressful and is related to depression is the kind that is forced and/or unwanted. Many kinds of unwanted subordinacy are easy to see: being bullied, for example, and/or criticized and unsupported, being treated by others like inferior subordinates. Other cases are more

subtle. Darren's wife Anne had an affair with another man. Darren concluded this was because she preferred this other man; therefore, in Anne's eyes, he was inferior to her lover and as an inferior would lose any 'battle' to win her love. He became depressed, with an acute sense of being in a subordinate position (to the other man) and not able to do anything about it except be angry (and risk driving his wife away) or leave someone he loved.

To show you how, for humans, our 'new brain thoughts' are often involved in our sense of (stressful) inferiority, consider two overweight women. One says, 'Well, I would like to be thinner for health reasons but hey, "big is beautiful" and I am a really nice person. I just have to keep trying.' For this person her weight may be a disappointment, but is not related to feeling inferior 'as a person'. But the other woman thinks, 'Oh God, I am so fat nobody will love me. When I look at the magazines I see how thin those women are. I can't let others see me like this. I will hide away and not go out to nightclubs or parties.' This woman has an acute sense of inferiority and of being subordinate to other (less weighty) women. And because she hides away, she reduces input to her positive feeling systems, which then get toned down further, making her more depressed and maybe eat more – it's a sad, vicious circle. Subordinate animals also lurk at the edges of their groups and, when we feel like this ourselves, we too might try to hide away, not going out much, which makes us more lonely and isolated. We also give up doing things that stimulate positive feelings.

You have probably noticed yourself how your moods can seem to make you behave more or less like a fearful, unconfident subordinate. One day you might just feel down. The confidence that was previously there feels as if it has suddenly gone, and you don't feel like facing the world. Or think of the extrovert man who loves parties but then gets depressed. An invitation for a party drops through his door: he feels anxious about it, and thinks it is all too much effort. He does not go. So you can see that mood seems to be strongly linked to feeling subordinate in some way, and prompts us to keep a low profile and stay on the edge of things even when we don't really want to be like this.

If we can learn to recognize compassionately that these inferiority thoughts are linked to this subordinate system that has been triggered, step back and decide to be gentle, kind and supportive and (as best we can) resist hiding away, this can move us forward. Whatever our source of stress, when we experience kindness, support and encouragement, we are stimulating systems in our brain that soothe the stress system. This is the story I will come back to time and again.

Feeling defeated

Feelings of *exhaustion and defeat* often pervade our experience of depression. The key feature of defeat is having engaged in some kind of struggle to do or achieve something, and feeling one has lost. Defeat states are designed by evolution to make those who lose a contest tone down their efforts and pleasure. Think of how losers in competitive sports behave, in contrast to winners. The winners go out on the town to celebrate; the losers may prefer to slink off home, not wanting to socialize much. Although some losers are more graceful and resigned to the outcome than others, these are pretty universal reactions, though of course they vary from very mild to

severe.

Exhaustion and defeat states can be extremely painful and there are ways of thinking that make the acceptance of defeats even tougher. Some people take defeats as evidence of some personal inadequacy. This eats away at the inner sense of oneself. We may set ourselves up for this by thinking that being an 'okay person' depends on being successful. If so, what happens if you try for something and fail? Then, by definition, you are not an okay person. By thinking in certain ways, we can allow a defeat to make us feel like failures – subordinate and inferior. If feeling overwhelmed with exhaustion and a sense of defeat (maybe you failed an important exam or broke up with someone, or are struggling with children) then this can trigger suicidal feelings of escaping. If possible, try to recognize this as a brain state, be kind to these feelings but do not try to act on them – give yourself time to let things settle and recuperate. Remind yourself of other times you have come through; consider how others have also had these setbacks rather than feeling ashamed. If possible, talk to your family doctor.

Unrealistic standards

We are often told, 'whenever things don't work out, try, try and try again'; or, 'you can do anything if you really want to and try hard enough'; or, 'if X can do it, so can you'. Sometimes this is encouraging, but at other times it is very silly advice. Sure, these slogans can inspire us to put in effort; but they can also set us up for impossible dreams and expectations which cannot be met and so will end in defeat. We need to have realistic expectations. We can set ourselves up for feelings of defeat when we aim too high, trying to be perfect and/or never to make mistakes. Since this is impossible to achieve, we will feel constantly defeated and depressed.

Others are better than me

We can feel defeated when we look around us and compare ourselves with other people. They seem to be coping better, seem less tired or angry, or are dieting better or succeeding more than we are. Try as we might we feel inferior – and with help from the media we can get a sense that we are 'not making it' while other people are – leaving us feeling defeated. This is also a theme of shame, a subject we shall consider in detail in Chapter 17. Our research has shown that people who feel they need to strive to prove themselves worthy, with the fear of not keeping up, and feeling inferior, are vulnerable to depressions.

Self-criticism on top of a sense of defeat

Our anger at the disappointment of a defeat can turn into an attack on the self. Depressed states of mind often focus on feeling worthless, inferior, not up to it and inadequate compared with others. The messages that others, or we ourselves, are giving us are not messages of love, acceptance and value, when we need these things most, but of criticism and put-downs. The more hostile the criticism, the more the stress system is activated. In many depressions there is a connection between feeling defeated, feeling subordinate and inferior, and continually knocking ourselves further down.

Chronic conflicts

Feelings of defeat can come from chronic conflicts in our relationships that we never seem able to resolve. Often these involve much (usually unexpressed) anger, accentuated by a feeling that we always lose these battles, or ‘can’t afford’ to say what we ‘really feel’. For Fran, the conflict was with her mother. Whatever she did, her mother would always find fault and tell her how she should have done it. Fran never felt able to tell her mother what she felt about this, and developed a deep sense of being no good, and that whatever she tried to do it would never be good enough. If they did have arguments, it always felt to Fran that her mother was by far the stronger person, and exerted a hold over her. Fran often felt like a defeated subordinate in many of her relationships.

Entrapment

The ‘defeated depressed brain state’ is particularly likely to be activated in situations of enforced subordination and entrapment. Someone in an unhappy marriage or a terrible job, or living in a place they hate but can’t get away from, can easily come to feel stuck, with no way out. This kind of perceived entrapment is a chronic stressor. Here are two examples.

- When David, a highly paid executive, had to put in increasingly long hours at work, he came to hate his job. The situation was made worse when a new, overly critical boss arrived. However, David had a big mortgage, had got used to a certain lifestyle, and could see no way of getting another job. He felt trapped in a position where he was being constantly pressured and criticized. Stress built up and depression set in – as it can when we are overloading our stress system.
- Cathy lived in a poor area with high unemployment. With an abusive husband and little money of her own, she felt totally responsible for her two children. She felt trapped, put down and unsupported.

My colleagues and I have been exploring feelings of entrapment in depression, and we have found that many depressed people feel trapped. This is often associated with wanting to run away or get away. Sometimes people are simply not able to do this because they don’t have the resources or there is nowhere to go; or they may stay because they feel guilty about leaving or moving away from others. Sometimes actually getting away is helpful, but at other times exerting more control or becoming more assertive reduces the desire to escape. The key point is that strong desires to escape means that the threat self-protection (in this case) fight/flight system is constantly active. The more people want to get away, the more they are likely to be in a state of high and long-acting stress. And, of course, the more they brood on their entrapment, the more stressed and depressed they will be. This state will gradually tone down positive emotions and systems. If these feelings and brain states are getting too much and you are thinking of self-harming then do talk to your family doctor, as there are many things that may help you.

Overview

It is clear, then, that certain states of mind and brain patterns can be turned on by certain situations. There are two particular reasons for exploring these ideas with you here. First, it will help you to make sense of some of your experiences of depression. It is not just *any* stress that can trigger depression, but *certain kinds* of stress. It is

stress that is related to (perceived or actual) losses and defeats, which often cause people to feel ‘separate’ from others, inferior, worthless and trapped. These seem the most crucial aspects of the stress–depression linkage. Second, if you think of depression as being a brain pattern, which exists in our brains because of evolution, and which has been triggered in you, you’ll see that depression is one of many potential states of mind; it is no more the ‘real’ you than any other state of mind one might be in. By recognizing that depression is not our fault, but is linked to how our brains work (that is why it feels so horrible), we can learn to stand back and heal this brain state. We can feel terrible pain if we break a leg because of how our pain systems evolved and work – however, that feeling of pain is not our fault – but doing all we can to get the leg fixed is our responsibility, of course.

When and why depression is not adaptive

Although life has got much easier in many ways for a lot of us (we in the West suffer less disease, famine and war than our ancestors) there are also many stresses and strains on us now that were not present as we evolved – and these, frankly, can overtax our systems. Culprits might include overworking and generally competitive lives (e.g., working long hours to keep our jobs; women competing to be thin with computer-enhanced images in the media); segregating systems (e.g., women on their own trying to cope with young children); and exclusive tendencies (e.g., poorer people being unable to gain access to the benefits that wealthier others can afford, while being only too aware through the media how much others have). Although marriage works well for many, we are not monogamous by nature. When relationships go wrong, we can feel trapped in them. Even the concrete jungles we have built that starve us of green and open spaces can be linked to depression.

In the past few years a number of books have appeared that explore this issue of how troublesome our innate needs (e.g., for love, status and approval, friendships, a sense of belonging and community) can be in modern societies – which do not always respect them.⁵ One consequence of this discrepancy is that our stress systems have become too easily triggered, are too intense for the level of actual threat, and stay turned on for too long. A mixture of the circumstances in which we are now living and our self-aware and self-judging thoughts contribute to this. Training our minds to move away from depression and develop more compassion and sense of connectedness is very urgently needed these days.

KEY POINTS

- Depression is a powerful state of mind that is related to biological processes. Your brain is in a different physical state when you are depressed from when you are not. This is important, and helps us to acknowledge the inner felt sense and bodily feelings of depression. On the other hand, all states of mind, be they happy ones, telling jokes, or concentrating on a mathematical problem, are associated with different brain states – so there is nothing special about this idea.
- Sometimes depression results from something that has been ‘turned on’ in us. Just as a painful state of grief can be turned on by the loss of a loved one, so too ‘depressed brain states’ can be turned on by the problems we have in our lives and how we come to view them.
- There are aspects of depression that seem to relate to mechanisms in the brain that evolved long ago (e.g., for coping with loss of loved ones and/or coping with being subordinated and/or defeated and/or trapped).
- Depression therefore tends to focus our minds on certain kinds of thoughts, e.g., unlovability, inferiority, defeat or entrapment.
- Once depression starts, our thoughts can play a powerful role in whether the depressed state remains

'turned on' or comes back under our control.

- Self-attacking may activate more stress, whilst being self-supporting and kind to ourselves may reduce it.

Bodies, genes, stress and coping: More on the mind–body link

When we feel depressed we can feel tired and aimless; we may not be sleeping well and so feel exhausted. We can also feel physically unwell and ‘heavy in the body’ compared with our normal selves. One patient said, ‘My whole system seems stuffed with black cotton wool.’ This is because when we become depressed there are very real changes in our bodies and brains. The fact is that our brains work differently when we are depressed. Depression is as much a *physical problem* as a psychological one. Although we sometimes still tend to think of the mind and body as separate, they are not. The mind and body are one. Over 2000 years ago, the Greeks thought that depression was caused by too much ‘black bile’ in the body. Indeed, ‘melancholia’, another word for depression, means ‘black bile’. Although, as they were well aware, this raises another question: What causes the black bile to increase? The Greeks had rather good ideas about this. They thought that there were people who ‘by their nature’ had more black bile – melancholic types. But they also believed that stress, diet and seasonal changes could affect the amounts of black bile in the body. The Greeks recognized that we can be upset by things that happen to us and that these upsets can affect our bodily processes – that is, affect the black bile. Their approach to depression was the first truly *holistic* one, taking body, mind and social living into account. Today, we call this holistic approach the *biopsychosocial* one. This simply means that we need to understand not only the bodily and mental aspects of depression but also the interactions between our biology and bodily processes, our psychology (how we think and cope) and the kinds of social circumstances in which we live.

Today we no longer think in terms of ‘black bile’ but in terms of chemical changes in the brain and other bodily processes. However, the idea that some people are, sadly, ‘by their nature’ more prone than others to certain types of depression has been confirmed by research.¹ Research has also shown that most depressions arise from combinations of early life experiences, current life events, lifestyles and the way we cope with them. Our central task in this chapter is to understand how these interact to produce the bodily and mental states of depression. The more we understand these interactions, the more sense it will make to help ourselves by using some of the methods outlined later in this book.

Biological aspects

The brain is affected by depression in many ways. The sleep system is disrupted; the

areas of the brain controlling positive feelings and emotions (joy, love, pleasure, fun) are toned down; and the areas controlling negative emotions (anger, anxiety, jealousy, shame) are toned up. In other words, when we are depressed, not only does life stop being enjoyable, but we are also more anxious, sad, irritable and bad-tempered. These changes in our feelings happen because there are changes in the way messages are relayed between one nerve cell and another in the brain.

Chemicals that operate as messengers between nerve cells are called *neurotransmitters*. There are very many different types of neurotransmitters in the brain. One type is called *monoamines*. These include dopamine, noradrenaline (norepinephrine) and serotonin. These three neurotransmitters control many functions in the brain, including appetite, sleep and motivation and are especially involved in moods and emotions. In depression these mood neurotransmitters are believed to be depleted and not working efficiently. The same may be true for transmitters that influence the soothing system and give rise to feelings of calm, safety and peaceful-contentment feelings, such as the endorphins (natural opiates) and the hormone oxytocin.² These are important chemicals in our brain, which are responsive to feeling cared for. A key question is: why have these changes occurred in the brain, and what can we do to help us to recover?

In fact, there are various ways in which our mood chemicals can be affected to make us vulnerable to depression. The three most important are our *genes*, our *history* and *current stress*. Let's look at each of these in turn.

Genetic influence

Genes are segments of DNA that control a vast number of chemical processes in our bodies and brains. The genes we inherit from our parents are the blueprints from which we were created. The first possibility, then, is that there is an *inherited* biological sensitivity to depression. On the basis of current evidence, it does seem that there is a genetic or inherited risk for some forms of depression; vulnerabilities to depression can run in families. Genes may affect the ease with which depressed brain states are activated by life events. They can also affect how we cope with life events and how we cope once we become depressed.¹

We must be careful though not to draw over-simplistic conclusions from these findings, such as 'all depressions are inherited diseases'. In the first place, much depends on the type of depression. Some depressions (especially bipolar or manic depression) do have a high 'genetic loading'. In addition, some people have an increased risk of certain types of depression if some of their close (genetic) relatives have certain disorders, including anxiety and alcoholism. Over the years there have been studies on thousands of twins, and genes seem to affect many behaviors and personality traits right down to preferences in clothes and food! In fact recent research shows that there are a number of *different* genetic vulnerabilities to depression. Most of these interact with life events and early life experiences to influence whether depression occurs or not.¹ However what is also very important is that research shows that even if we carry a genetic risk for certain depressions, the kind of early life we have may do much to change or even remove this risk – and the kindness we experience is key.

Early life and how the brain develops

Although genes give us a blueprint, pathways in our brains (and our mood chemicals) develop from the experiences we have. We now know that the brain is very flexible or ‘plastic’ in this regard: it’s called *neuroplasticity*.³ The brain of a child who is loved and wanted will mature differently from that of a child who is abused and constantly threatened. Indeed, research has shown very clearly that love and affection, in contrast to coldness and abuse, affect the way areas of the brain that control moods and emotions develop. For instance, there is increasing evidence that many people who are susceptible to chronic forms of depression have histories of abuse, and that the stress systems of some of these people have an increased sensitivity.

As we come to recognize our own personal sensitivities, psychological understanding and training can do much to help us cope better and change our sensitivities. However, prevention is of course better than cure, and the more we understand about the role of our early relationships in how our brains mature, the more seriously, as a society, we must take childcare.

Stress and depression

Many depressions are triggered and maintained by stress. Stress can be a source of many different psychological problems, including anxiety, irritability, fatigue – and depression.⁴ The way we cope with stress, too, can give rise to different psychological problems. Some people under stress are able to recognize it and back off from what is stressful to them. Others, however, are not able to escape from things that are stressful; for example, if we are in a job or a relationship that is ‘stressful’, it may not be easy just to walk away. Other ways of coping with stress may cause problems of their own: for example, drinking too much alcohol. Before we look at how our thoughts and coping efforts can make stress worse, let’s explore what happens in the body when we are stressed.

Stress and our bodies

In recent years there has been growing interest in how stress (arising from the threat-protection system) works in depression. For example, one effect of stress is for adrenal glands to produce more cortisol. Cortisol is an important hormone that circulates in the body all the time, increasing and decreasing over each 24-hour period. This hormone does some useful things. It mobilizes fat for use as energy; it has anti-inflammatory properties; it is involved in the functioning of the liver; and it may also increase the sensitivity to and detection of threats. This all seems very positive and useful. When we are under chronic stress, however, the amount of cortisol circulating in the blood is increased, and it turns out that a *prolonged* high level of cortisol is bad for us. It is bad for the immune system (indeed, the effects of cortisol may be one of the problems in those who suffer from chronic fatigue syndrome), and it can cause undesirable changes in various areas of the brain that are involved with memory. Problems with memory and concentration may well be symptoms of excessively high cortisol levels. Cortisol also affects our mood chemicals. It can also make us hypersensitive to threats, which is not necessarily useful if it makes us focus too strongly on the threatening and negative aspects of

situations and events. Research has revealed that many depressed people have highly stressed-out bodies with increased cortisol levels.

Let's think about another important aspect of stress: control. Can we control the effect of stress on us, and what happens if we can't?

Uncontrollable stress

Over 40 years ago, the American psychologist Martin Seligman found that, if animals were put under stresses that they could not control, they would become very passive and behave like depressed people. This did not happen if the animals could control the stress. These extremely important findings were later taken up by other researchers who wanted to see what changes took place in the brains of animals subjected to uncontrollable stress. It was found that some of the changes were similar to those associated with depression. For example, activity in areas of the brain that control positive emotions and behavior was reduced, stress systems went into overdrive and the mood chemicals – dopamine, noradrenaline and serotonin – were depleted. However, if other animals were subjected to the same stress *but had the means to control that stress*, different changes took place: the areas of the brain that control positive emotions and active (rather than passive) behavior were toned up and the mood chemicals were enhanced. This tells us something very important. The same stress, but with different levels of control, can produce quite different changes in our bodies and brains. If you are stressed and can do something about it, your brain will react in one way; but if you think you can't do anything about it, it will react in a different way. The way you cope with stress is a key issue. Although taking control is not always easy, as we will see, there are many things that we can do to help us have more control over our lives and depression and thus influence our mood chemicals.

The straw that breaks the camel's back

We often talk about 'the last straw' because we know that stress can be cumulative – it builds up. Take Nicky. Her firm was experiencing financial difficulties and she believed she was likely to lose her job, leaving her with a very uncertain future. The threat of redundancies had been hanging over the office for a couple of months and the atmosphere at work was very gloomy. Then, driving home late one evening, she was involved in a car crash. Responsibility for the accident was unclear, but she felt that it was partly due to a lapse in concentration on her part. She wasn't seriously injured, but her car was damaged and she was shaken up for quite a while. As she was recovering from this, her mother had a heart attack. Nicky had not been sleeping well for a month or so, and shortly after her mother became ill her sleeping became even worse. She began to brood more and more on the car accident and her responsibility. She also thought that maybe the worry of all that had contributed to her mother's heart attack, through stress. She felt she should do more to help her mother, but found that visiting her took up a lot of time and energy. She began to feel very low in mood, increasingly anxious and irritable, and personally inadequate; she found it difficult to get out of bed in the morning, and was prone to thinking 'There is not much point because things just happen out of my control.' Not being able to 'get her old energy back' was itself depressing.

In many cases of depression there is a combination of stresses and setbacks. There may be financial worries, worries over a job (or lack of one), conflicts at home or at

work, children having problems, health worries and so forth. Over time the cumulative effect of these difficulties increases stress and edges us closer to maladaptive feedback, where we begin to ruminate on all the problems and spiral down into depression.

The small things get more difficult

One of the things that many people notice as they become depressed is that small things, or things they used to do easily, like calling the garage to have the car fixed, or having friends over for dinner, or queuing in the supermarket, become filled with anxiety or are hard to do. They start putting them off, and at the same time worrying because they have not been done. Suddenly, small things become big things. If this happens, then recognize your anxiety is a normal (if unpleasant) effect of your over-stressed brain state and will settle as you get better. Try as best you can to do those small things and not let them build up and get on top of you. You will feel better for it, even though it may take a lot of effort; whereas if you do put them off, you may start to brood on them and that will increase your stress. Recognize that your experience is a common one, and doesn't mean that you are 'personally useless'.

Stress spirals

A lot of what we try to do when helping people cope with depression is to stop spirals of stress. All kinds of events can happen to us at any time. Our plans and aspirations may not be working out; our relationships may be falling apart; we may be involved in car accidents, financial reverses and health changes. Or we may simply be overworking, trying to cope with the demands of a job, children or both, caught up in the 'hurry, hurry' society. All these experiences can be stressful to the extent that they tax our stress systems, raise cortisol levels and deplete mood chemicals. As the amount of cortisol in our system goes up, we become more focused on the negative, more fatigued and more stressed (see Figure 4.1).

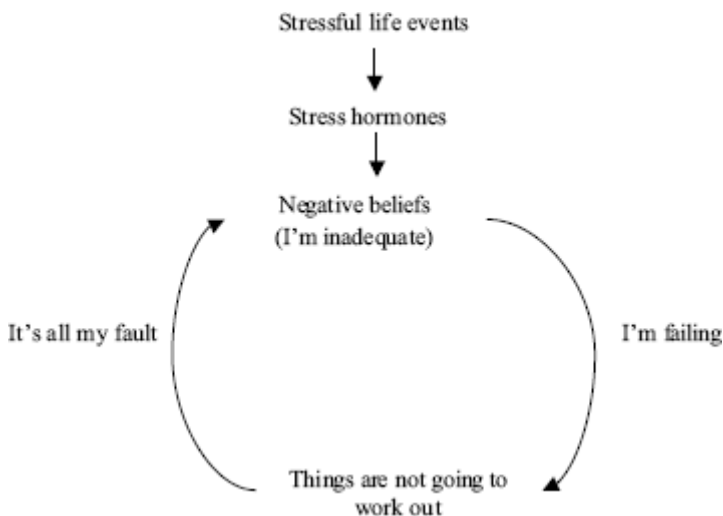


Figure 4.1 Relation between stress and thinking.

Stress and built-in irrationality

There are many times in life where our decisions are not based on rationality. Falling in love, choosing this career over that one, wanting children, liking this movie but not that one, are all based on how we *feel* about things. Our feelings can be automatically triggered and affect how we think about things and what we do. So there is another reason why we can become more focused on the threats and losses and become locked into the kind of loops described above. *Our brains are built to be irrational at times!* Consider an animal peacefully grazing in an open field. Suddenly its attention is drawn to a movement in the grass. What should it do? Should it ignore it? Wait to find out what it is? Or get the hell out of there? In many cases in the wild, the best thing to do is ‘get the hell out of there’, because the movement could be a predator. In fact, the grazing animal only has to make the wrong decision (underestimate the danger) once, and it’s dead. It would be far better to run away when there was no need to than stay and take the risk. If the animal runs away it has lost some time feeding, but it is still alive.

When we are under threat, our brains have been designed to work on a ‘better safe than sorry’ principle. That is, our brains were designed *not* to think rationally in all situations, but at times to jump to conclusions and assume the worst, which allows a rapid response if needed. It does not matter that this jumping to conclusions could be wrong, only that it works and protects us. The strange thing about this is that it means that *the brain is designed to make mistakes*, especially when we are under stress: to lead us to assume the worst and take defensive action unnecessarily. It helps to recognize that when we find ourselves being irrational and assuming the worst, this is not because we are stupid but because the brain has a natural tendency to do just that – to *catastrophize*. Today, jumping to conclusions and assuming the worst can lead us to feel pretty miserable and lock us into stress loops (see Figure 4.1), so we need to train our minds to help us gain more control over our feelings. This is the focus of Parts II and III of this book.

It is important to note though that even though this is not our fault (because we did not design our brains like this) our thoughts can amplify the bodily stress response and affect how our brains are working. Remember the examples we used on pages 28–29. This capacity for our thoughts, images, memories and coping efforts to stimulate our emotional and physiological responses is profoundly important. When people start to work on their depression, it is not uncommon for them to say: ‘But surely my thoughts can’t make me *feel* so bad?’ or: ‘Surely changing my thoughts can’t make that much difference and affect my body?’ The answer is yes, they can. Of course, there is much more to depression than depressive thinking; but imagine walking around in the world thinking that you are unlovable and worthless, or focusing on how depressed you feel, or ruminating on your anger and loneliness. Very understandable, of course, but what do you think will happen to your stress and mood systems? Unfortunately, if those things go over and over in your mind, your stress system will release stress hormones. Noticing and then trying to interrupt this feedback is one of the things this book will help you with.

Of course, breaking out of the loop may not be easy. People who are vulnerable to depression may not have anyone they can ask for emotional support, or they may feel ashamed to ask. We will discuss this later; but you can see that at some point we need

to break this loop that will lead into a downward spiral. If you are so exhausted that you can't sleep and life has become very black, you may need to try some medication. But we also need to stand back and look at how we think and how we cope, and recognize how our threat-focused thoughts (natural though some of them might be) are too much in control of our minds.

So depression is not just psychological, or 'all in the mind', and certainly not a sign of a weak character or anything like that. Depression is about how our bodies and brains respond to stress, and about our genetic and developmental sensitivities.

Being depressed and tired can itself be stressful and depressing. If you feel ashamed of being depressed, remember that you did not design your body to respond in the way it does – you'd much rather not be stressed and depressed. If you don't like the term 'depression' then tell yourself you are exhausted or burnt out or in cortisol overdrive, and seek help – but recognize that there are things you can do to help you regain some balance in your three systems (see page 17) and bring your stress spirals under control.

KEY POINTS

- Depression involves changes in body and mind.
- Some people have a genetic risk of depression, but biological sensitivity can also arise from early life experiences.
- As we become stressed, biological changes take place in the brain, and these can lead us into downward spirals.
- Some of our negative ways of thinking are due to the way stress works, making us focus on the negative and assume the worst.
- Learning to exert more control over our lives and our thoughts can help us in many ways, not least by giving our brain chemistry a chance to recover.

Early life and the psychological and social aspects of depression

When psychologists explore depression they focus on two key areas. The first is how we *give meaning* to events and feelings. To one person, a divorce is a tragedy; to another, a relief. To one person, feeling angry is empowering; to another, it's frightening. The second area is how we *cope* with life's difficulties. Some people are able to break problems down into manageable tasks, seek out help from others and plan ways to overcome the difficulty, whereas others feel overwhelmed; they don't share their problems, but hope they will just go away.

These two processes, how we give meaning to events and how we cope, are key to an approach to therapy called *cognitive behavior therapy*¹ or CBT for short. As we'll see as we go on, learning compassionate thinking and behavior uses a lot of CBT ideas and ways of working and is key to helping us work with our depressions. Of course what is happening in your life is important to your feelings. If someone is threatening or assaulting you then you are likely to be experiencing the world in a certain way; our thoughts, feelings and mood states are linked to the *contexts* of our lives. It is not that our thoughts 'cause' depression, but rather that they contribute to depression.

Giving meaning

There are many ways we *give meaning* to feelings and events, and some meanings are more likely to increase depression than others. The cognitive approach suggests that particular kinds of thinking go with particular kinds of problems (see Table 5.1)

TABLE 5.1 THOUGHTS ASSOCIATED WITH PROBLEMS

Problem	Thoughts
Panic	I am going to die from these symptoms of anxiety.
Social anxiety	I will do something that will make me look foolish/stupid and I'll be rejected or shamed.
Depression	I am a bad/weak/inadequate person and the future is hopeless.
Paranoia	People are out to get me.
Anger	Other people are bad/unkind, are treating me unfairly, or taking advantage, and deserve to be punished.

By focusing on the *thoughts* that are associated with certain types of problem, we can learn to see how much our depressed moods push and pull us to see things as major threats, stimulating the threat self-protection system. CBT then helps us to test the evidence *and usefulness* for our thoughts and learn to generate alternatives – to balance our thinking. Being depressed often goes with feeling and thinking in certain ways (e.g., feeling defeated, subordinate, inferior). However, this suggests another question. How did we get into thinking negatively in the first place?

Early life and core feelings and beliefs

There is now a lot of evidence that early life experiences can *biologically* sensitize people to certain forms of stress and overstimulate their threat-protection systems.² We know that the types of love and affection children receive have an impact on their brains and how those brains grow and mature.³ We also now know that children with different genetic profiles can be more vulnerable and at risk of mental health problems in the context of difficult early life experiences.⁴ According to CBT, when we are young – and throughout our lives too – a variety of influences (including genetic) and events create within us emotional dispositions and *basic* or *core beliefs* about ourselves, others and the world. Let's look at how these are formed.

Core beliefs about oneself are fused with emotions

We all have core beliefs about the world – that the Earth goes around the Sun, or the Earth is round and not flat. These are linked to our fundamental ideas and knowledge about how the world is.

We also have another set of core beliefs based on our sense of self and other people. These core beliefs are very different from simple knowledge-based ones because they are fused with emotion. A self-focused *core belief* is something that you feel is basic to you. You might say, for example, 'When all is said and done I feel *this* about me,' or 'At heart I feel ...', or 'Right in the centre of me I feel ...'. Suppose a parent is angry with a child and calls her stupid. The child not only hears this label being used to describe her, but also has a fear. She *feels* stupid and has a sense of

shame. The feeling of fear, shame and the label of 'stupid', *are fused together* in that moment. You can imagine what feelings might come back to her if she makes another mistake. Over time these feelings about herself may become part of her 'felt sense of self', the kind of person she feels herself to be.

When something unpleasant happens it is usually the emotions and feelings that strike us first; only later do we recognize that these feelings are associated with core beliefs, memories and ideas about ourselves. Let's work through an example to explore this. Sally had a fairly neglectful upbringing. When she was still relatively young, her mother told her that she had got married when she became pregnant with Sally. Unfortunately, the marriage was unhappy and her mother would ponder on how things might have been different for her had she not got pregnant. She would often say, 'If it hadn't been for you, I would have done such and such.' Sally felt that her mother saw her as the reason she had not done more with her life. Generally, these comments were not said in anger but with regret and sadness. At times, Sally's mother had strongly hinted that she felt like leaving home. Sally had taken these 'hints' as serious threats of abandonment, and gradually developed certain beliefs and ideas: 'I am a nuisance to others. I stop people doing what they want to do. People don't really want me around. I must not do anything that might push them away. Others might leave me at any moment.' Remember, these beliefs will be *glued in place with emotion*.

Sally carried these basic beliefs inside her throughout her life. Whenever there were conflicts, she would feel anxious and think/feel, 'Maybe I'm being a nuisance' or 'I must let others do what they want to do.' If she ever felt that she was putting others out, or letting them down, she would feel very guilty. A major unintended consequence of this way of being was that in trying to *protect herself* from others not wanting her around, she found it difficult to assert herself. She was constantly on the look-out for clues that she was being a burden to others. When an important long-term relationship with a boyfriend broke up, her automatic thoughts were: 'Well, I guess nobody really wants me. I am just a nuisance. I will never be loved for myself.' So her self-protection system quite understandably made her rather submissive, but the safety strategy had unwanted consequences.

As you might guess, underneath Sally's surface set of beliefs was another set. Here there was a high *degree of anger*. Having to give in to others all the time (in effect, subordinating herself to the needs of others) had led to feelings that this was unfair. After all, Sally hadn't asked to be born. Why should she have to keep doing what others wanted? Why was she so unlovable? But, of course, she thought that if she asserted herself, this would expose her to threats of abandonment and feeling a nuisance. If anyone made her very angry these inner rage feelings would be very frightening to her, because then she would feel others *really* wouldn't like her. These feelings had to be 'repressed' and avoided. She also felt, since her mother had done her best for her, that she had no right to be angry with her mother. Even thinking about her anger towards her mother for her threats of abandonment made Sally feel bad, like a traitor, and more stressed.

As you can see, and we will go over this many times, our thoughts are complex and can take us on a downward spiral into depression: as we become stressed and depressed, we have more negative thoughts; emotions of shame or fear of abandonment come back, we become more depressed with more negative thoughts and feelings.

Here is an overview of Sally's beliefs and feelings and how they affected her:

EARLY CHILDHOOD EXPERIENCES

- Mother said that had it not been for me she would have done more with her life.
- Worried that mother might leave one day.

BASIC BELIEFS FUSED WITH EMOTIONS

- I am a nuisance to others.
- I stop people doing what they want to do.
- People don't really want me around.
- I must not do anything that could push them away.
- I must be to others what they want me to be.
- Expressing anger and/or asserting my needs could lead to rejection.
- I am a bad/ungrateful person if I express my dissatisfactions.

BASIC SOCIAL BEHAVIORS AND SAFETY STRATEGIES

- I am not assertive.
- I avoid conflicts.
- I don't initiate things I want to do.

DEPRESSION-TRIGGERING EVENT

- Break-up of a relationship; loss of a valued person who blamed me for being rather boring.

TYPICAL THOUGHTS

- I am a nuisance to others.
- It would be better if I weren't here.
- Relationships are too difficult.
- I can't bear to be alone.

SYMPTOMS

- Poor sleep and exhaustion.
- Constant thinking about loss and self-blame.
- Feelings of worthlessness.
- Loss of pleasure and capacity to enjoy things.
- Feeling that the future seems hopeless.
- Weight loss.
- Inner feelings of emptiness.
- Increased fear and general feelings of disorientation.

You may have noticed two things about Sally. First she was very anxious about forming close relationships, and felt vulnerable to being left and abandoned. That anxiety and fear fuelled the underlying stress. Second, the way she behaved and coped with this – her self-protection strategy – was to act like a subordinate or even a servant. Her relationships did not boost her self-esteem very much. Indeed, apart from making herself 'fit in with others', she felt that she had no power to hold on to

good relationships. When it came to asserting her own needs and opinions, she felt that she had neither the right to do so, nor any justification for doing so. Without a lot of reassurance, she felt empty and vulnerable, and often felt inferior and subordinate to others.

Sally's threat self-protection strategy was designed to help and protect her as best it could when she *was a child*. Being subordinate and trying to make Mum love and want her was very sensible for a vulnerable child, but through no fault of her own this strategy got her into serious problems later in life and stunted her growth. This is one example where we can see that depression is not our fault and neither is it the fault of the threat-protection strategies – it is an unintended effect of early efforts to get safe. The same is true for children who learn to be aggressive to defend themselves; this attitude may well get them into serious trouble later in life. These early self-protection strategies can be tricky to spot and to change. That is why training our minds becomes so important to understand.

Try this: Sit quietly for a moment and then focus on as much kindness as you can within you and reflect if there is anything about Sally's story that resonates for you. If there is, be gentle and kind about that. If you feel upset, go back to focusing on your inner kindness. If that is difficult – notice this and return to reading.

The role of early traumas

One powerful way in which some individuals learn how to judge and rate themselves is through having very painful experiences in childhood. For example, if they have been sexually abused, they might come to feel that sex is bad, disgusting, dirty or dangerous, and that they themselves are in some way bad or dirty and their sexual feelings are dangerous. In effect, the trauma robs them of their sexual lives and feelings of goodness.⁵

Sometimes parents are unable to cope, and when things get tense, they lash out at their children or call them names. This is intensely painful for the children, who find it difficult to recognize that their parents have a low tolerance for frustration. The children on the receiving end of this rage may blame themselves and think that they really are very bad. Sometimes parents are unable to give their children physical affection, perhaps because they don't know how or because they feel very awkward about it. One of the saddest things is that some parents still think that being physically affectionate towards their children, especially their sons, will turn the boys into sissies. As we have seen, affection is in fact very good for our brains (see pages 23–26).

AFFECTIONLESS CONTROL

Research has suggested that many depressed people can look back and see that their early life was often rather barren of affection, and sometimes even very harsh. Parents may have demanded high standards or have been very controlling. This is called *affectionless-control parenting*. Because most of us, as children, are unable to see our parents as flawed individuals with problems of their own, we tend to think that the way they treated us was our own fault; there was something about us that made them behave in the way they did. If they were very critical of us, we tend to carry on the tradition and be critical of ourselves. However, with understanding, insight and hard work, we can change these habits and learn to be compassionate

towards ourselves.

UNPREDICTABILITY

Another very common pattern we see in the lives of depressed people is that their parents were unpredictable. These are parents who can be very loving and kind, but then are not available, leaving the child with yearning; or they can become aggressive, say hurtful things and even be physically abusive. It is very difficult for the child's threat self-protection systems to sort out what is safe and what is not. A parent can be seen as a source of comfort, but also a great threat. This kind of conflict is known to cause difficulties in how our brains deal with relationships. Sometimes people find it very difficult to sort out the feelings of both love and also fear, at times even hatred, of the parent. Moreover, because the child (and later the adult) wants to be loving, they can have a negative view of their own anger towards the parents, or even be in denial about that.

UNRELIABILITY

Unreliable parents can also be problematic for our emotional development. These are parents who talk a lot about love and being in a loving family but don't always behave like that. For example, Kay's mother was so preoccupied with her career and marital problems that she did not really attend to her daughter's mood changes just before adolescence. Kay was being bullied at school and abused by the next-door neighbour, but felt unable to tell her mother. She found her mother was never really there to get close to, although she was constantly saying 'what a loving family we are'. Children who experience their parents as unavailable for protection or support, or for forming a bond with them, can be left with ongoing desires and searching for closeness. They often anticipate that people will be superficially nice but with no real depth to their affections.

RESCUER CHILDREN

Some children grow up in circumstances – maybe with both parents working or in single-parent homes – where they have to take on responsibilities (e.g., looking after siblings). Gradually they see themselves as needing to achieve things, to help or rescue the family. Their expectations of themselves and the demands they put on themselves get out of proportion and they end up feeling overwhelmed and fearful of failure and being unable to live up to the expectations they have set themselves – becoming very perfectionistic (see Chapter 21). They can have dark feelings of defeat and inner collapse.

These are some of the relational backgrounds that a depressed person may experience early in life. There are many others. The key thing is the way in which people experience a sense of connectedness and safeness in the world because they know they can turn to and rely on others.⁶ Our early relationships help us to experience the world as safe or dangerous, and this influences the balance of the threat and positive emotions systems we saw in Chapter 2.

Relationships and social needs

A lack of positive experiences (e.g., love, affection, support and care) in human relationships can be depressing. One reason for this is that the brain needs certain levels of positive inputs to maintain reasonable levels of mood chemicals and low levels of stress. On the whole, human beings throughout the world tend to be happier in some situations and unhappy in others (see Table 5.2).

TABLE 5.2 HAPPY AND UNHAPPY SITUATIONS	
Happy situations	Unhappy situations
Loved and wanted	Unloved and unwanted
Close to others	Abandoned
Accepted and belonging	Not accepted/rejected
Have friends	Do not have friends
Accepted member of a group	An outsider or ostracized
Have value to others	Have little value for others
Appreciated	Taken for granted
Attractive to self and others	Unattractive to self and others
Have status and respect	Losing status or forced into low status

The situations in the left-hand column are associated with low levels of stress hormone and tend to boost our mood chemicals. They are ‘feel-good’ things. Those on the right-hand side are associated with increased stress and dips in our mood chemicals. The reason for this is that the brain is wired up to want the ‘feel-good’ things. Individuals who were able to have these needs met, who were ‘socially successful’, did better in evolutionary terms than those who did not – they survived better and left more offspring. We are biologically inclined to try to achieve the things in the left-hand column and avoid the things in the right-hand column. Desires for social success are wired into our emotions. The more our beliefs begin to shift towards the things in the right-hand column, the more threatened and unhappy we are likely to become.

Core beliefs, caring and relating

As described above, we can develop core beliefs about ourselves that ‘at my core I am *this* or *that*’. Given how important relationships are to our feelings and moods, our feelings and beliefs about relationship can be important to how we create them, maintain them and cope with ending them. Depressed people can have very negative ideas about their ability to gain support, help, affection and approval from others. These beliefs might include:

BELIEFS ABOUT BEING A BURDEN TO OTHERS

- Nobody could care for me.
- My needs often seem a nuisance.
- It is pathetic for me to need love and reassurance.
- A needy person is a weak person.
- A needy person is a greedy person.

- My needs are far too much for anyone to cope with.

These beliefs can make it difficult for us to reach out to others. As you can imagine, they will also increase stress and make developing positive relationships with others more difficult. Talking to friends about these feelings can be helpful, because in this way we are making attempts to reach out to others and ‘owning’ our needs. Indeed, knowing what our needs are, and being able to express them, is important for mental health, especially if we are successful in eliciting supportive signals from others.

We can, of course, also have beliefs *about others*. These cover two broad concerns: the refusal or inability of others to care, and views that we are entitled to be cared for but others aren’t doing enough.

BELIEFS THAT OTHERS ARE NOT AVAILABLE OR WILL BE ANGRY

- Others are too busy to bother with me.
- They are not up to caring for me.
- They don’t understand.
- They will like me less for needing.
- They have too many problems of their own.

Exploitation and distrust

We are born with a sensitivity to cheating, because being cheated is a threat. Think how common it is for humans to feel angry at being cheated. Finding that your lover has been unfaithful, or that your friends have let you down, or that an important promise has not been kept – all these tend to activate strong negative feelings and low mood.

However, when we become depressed we can see deceptions almost everywhere because, under threat, the brain jumps to conclusions. When Jane returned to work after being off sick, her colleagues asked her how she was. But Jane thought, ‘They are only asking this to make themselves feel better, not because they really care about me.’ In effect, Jane was saying that her colleagues were actively trying to deceive her. When we are depressed, we become far more sensitive to the possibility that others are only pretending to be nice, that they are cheating us. And if we receive mild put-downs or people ignore us for whatever reason, we can read all kinds of things into that. This is because, when we are depressed, we are on the look-out for various kinds of social threat. Our basic beliefs can lead us to let these fears get out of hand.

BELIEFS ABOUT EXPLOITATION

- People really only care about themselves.
- If people are nice to me it’s because they want something.
- People act nice to make themselves feel or look good.
- People will use me until I am no further use to them.
- Others will exploit me if they know my weaknesses.

Status

As we saw in the last chapter, some of the issues in depression are about our social standing in the world. Do we see ourselves as equal to others or inferior? Do we feel defeated and losers, or winners? Do we feel we have the 'power' to exert some influence over our relationships, or do we feel other people have more power? Recent research has found that depressed people often feel that others have more power than they do. The following are examples of basic beliefs about our status.

BELIEFS ABOUT INFERIORITY AND DEFEATS

- Compared with others, I am not so good, I'm inadequate, useless, worthless.
- I lack confidence to get what I want.
- I must achieve great things to help others, or to prove myself, or to feel life is worth living.

When Mary lost her lover to another woman, it was not so much the loss that upset her (she had had doubts about the relationship and had wondered whether she wanted it to continue). Instead, her distress was focused on the 'status thought': 'What does she have that I don't? Maybe I wasn't so good in bed. Maybe I'm less attractive than I thought.' It was these concerns with *why* she had lost out to another woman that made her feel most depressed.

Inferiority beliefs show themselves in our feelings of shame and inadequacy. When John got depressed and lost an important argument at work, he thought, 'I didn't put my point of view well enough. I'm inadequate. I'll never be able to win when it matters to me.' As he said later when he felt better, normally, although he would have been disappointed by the loss, he had always lived by the motto: 'You win some, you lose some.' In this case, however, the disappointment and stress of losing had led him to start jumping to conclusions. Interestingly, at the time, his love relationship was not going well. This background stress could have elevated his stress hormone level and made it much easier for his brain to switch to feelings of defeat and inadequacy.

The different sides of ourselves and their conflicts

We have different sides to our personalities, don't we? We say things like 'part of me wants to do this but another part of me wants to do that'. The problem is that different parts of ourselves can be in conflict. Having inner conflicts is actually common and normal. If we think in terms of balancing our minds, then sometimes we need to think about what part of ourselves is *missing* just as much as what we express. For instance, if you look at the example of Sally, what do you think she is avoiding – anger and assertiveness, maybe? When we hear Sally's story we might feel angry at her mother for saying those things to her. We might feel the anger that Sally struggles with because she is frightened of it. Sally wants to be loved and accepted and is therefore frightened of anger and about how stirring things up in conflict might make people reject her. In our own lives we might avoid asserting ourselves to avoid feeling guilt or shame.

Our brains are actually designed to have conflicting emotions. For example, if someone criticizes, you might feel the anger *and* anxiety, but you can't express both at the same time. You might become anxious about expressing anger if it's towards your boss, or you might be angry with yourself at being too anxious. Sometimes we

can behave very submissively and then later, when we are alone perhaps, we ask ourselves, ‘Why didn’t I say that?’

As we go through this book we will keep this in mind, understanding that our brains can go *into conflict* over things: ‘Should I or shouldn’t I?’. Research shows us that our conflicts over what to do, say or think can be very stressing and – over time – depressing.

The social environment

It is also *very important* to recognize that the social environment has a major influence on our beliefs, feelings about ourselves, behaviors and moods. For example:

- Poverty is clearly linked to depression.
- In some parts of the world women are not allowed out without covering their faces with a veil. In other places women can dress and behave as they please – go skate-boarding in bikinis if they like.
- Some of us grew up believing that there is a God who can send us to hell if we’re too sinful, but others think this is sadistic nonsense.
- In some parts of the world children are likely to die before the age of five, while in other places, infant mortality is relatively low.
- In some of our inner cities crime, drug problems, intimidation, pollution and poverty are the rule, but in the leafy suburbs these are rare.
- Some of us grow up with happy, doting parents; others with violent, abusive and alcoholic ones.

Many writers and commentators worry that we’re creating mentally unhealthy environments – be this through the increasing selfishness of Western capitalism or our entertainments becoming more sadistic. Teachers are not able to hug distressed children for fear of prosecution. Constant school tests play children off against each other and focus on them being constantly judged and evaluated. To attract ever-shrinking audiences, TV programmers make programs where people are thrown out and shamed (*The Weakest Link*, *The Apprentice*), soap operas focus more and more on conflicts presenting people as highly self-centred and with low emotional control or kindness, and so on. All around us we are dissolving feelings of belonging, acceptance and tolerance. These social aspects will also be influencing our brains and moods. There is no question that some social environments are breeding grounds of stress and depression. In our rush for economic prosperity we don’t focus nearly enough attention on building societies that promote psychological health.

Life events and depression

Not surprisingly, then, depressed people often have a mixture of problems, internal (styles of thinking, negative feelings) and external. Poverty is strongly linked to depression, as are poor and conflictual relationships. Social researchers George Brown and Tirrel Harris have found that, in women, external, social factors play a large role in the onset of some depressions and in the recovery from them. They found that there are things that make us vulnerable to depression (*vulnerability factors and chronic difficulties* such as low self-esteem, low social support, and having to look after young children) and things that push us into depression (*provoking agents* such as a major event that can overwhelm us).⁷

Social roles

Social psychologists recognize that much of our self-esteem and stress comes from our roles as mother, father, worker, boss, lover, student, spouse, etc.; in other words, from what we do. Psychologists Lorna Champion and Mick Power,⁸ for example, have pointed out that our roles also give us a sense of self-esteem, status and some rank in society. Sadly, today, bringing up children and being a 'home-maker' or 'housewife' are not seen as roles conferring much status, despite these being some of the most important and emotionally taxing activities that people can tackle.

A major concern with depression in young people is that they may lack clear roles, especially if there are few jobs available, and they don't feel *part of integrated communities*. Feeling that we have something *to offer to others*, and that we are appreciated and valued for what we do, are important sources of self-esteem and social status. Jobs also give us some direct control over our lives, as well as allowing us to plan for the future and providing opportunities to interact with other people. Without jobs, we can feel unwanted by society, feel deprived of an identity, and find it difficult to make plans. We can also feel socially isolated. In my view a reason for the increasing rates of unhappiness, especially in our younger people, is that we are not providing important social roles where they can contribute *and feel included, needed and valued*.

Sometimes we invest a lot in a certain role, and then if that fails we go under with it. Consider Kath. She had always wanted to get married but had never met the right person. However, she had dedicated herself to nursing and this had become her life. Then, at the age of 54, she developed a serious illness, which meant that she had to take early retirement. Grieving for the one thing in her life that had given her meaning, she slipped into depression and gradually lost contact with her friends, especially those who were still working.

Social isolation

Some Western ways of life are rather isolating, but humans evolved to live in close-knit communities where children were not enclosed in small homes, but were mostly active out in the open, where friends and relatives could keep an eye on them. Young mothers and older people were certainly not separated from the working of the group, as they can be today. Some of the high rates of depression are due to *our abnormal social patterns and lifestyles*.

Depression can arise from real economic and social hardships. There may be things in your life that make depression more likely. Once you give up blaming yourself and feeling inadequate, you might begin to see how to make changes. It is also important to note, for example, that a life looking after children on your own does not necessarily lead to happiness. On the contrary, it has been shown that the arrival of children can lead to a reduction in happiness in the relationship of the parents. This is not to say, however, that children can't bring great pleasures. Indeed, some people become depressed when they lose this parenting role, as children 'fly the nest'.

Why are women more at risk from depression?

As noted women are around two to three times more likely to suffer from depression than men. There are various theories about why this should be so.

Biology

This view is that the higher rates of depression in women are due to differences in reproductive biology (e.g., the levels of certain hormones). Recent research suggests that emotional information may be processed slightly differently in the brains of men and women, although whether this increases the risk of depression is unknown.

Psychology

This view is that the higher rates of depression in women are due to differences in the way we are 'socialized' as we grow up. Women are brought up to be more accepting of subordinate positions, are schooled to be carers and, compared with men, encouraged to be less assertive or competitive. The incidence of sexual abuse is higher in women than in men.

The ways in which men and women recognize and cope with distressing life events may be different (e.g., women are more likely to focus on feelings and blame themselves). Women, then, are more in touch with and able to express sad and unhappy feelings; and they may be more vulnerable to 'lonely-based' depression. Women may dwell more on unhappiness, although this can be because they can be more socially isolated.

Social factors

This view is that variations in the incidence of depression between the sexes are due to differences in social opportunities and gender roles. Women are more likely to occupy subordinate positions in society and the family, to be restricted to the home and to be subjected to male dominance, even abuse. Marriage in particular may not always be helpful for women if it maintains them in subordinate positions with reduced opportunities to socialize with others and to engage in meaningful social roles outside the home. Spending time alone with children each day may be linked to some depressions.

My own view is that the differences in rates of depression between the sexes and also between different communities are, on the whole, due to a mixture of these factors but are mostly social ones.

Overview

There is, then, no single cause of depression. Although some of us are more genetically susceptible than others, part of the problem lies in how our brains were designed by evolution – and of course the social worlds in which we grew up and live. However, once we become depressed there are some typical things that happen, such as a shift in the balance of our inner systems towards more threat-processing (increased anger and anxiety and pessimistic thoughts) and a toning down of positive feeling (loss of drive and feeling of closeness to others and hopeful thoughts). If we work on these, in the various ways outlined in the next sections of this book, we might be able to shift the depressed brain state patterns into a new pattern.

KEY POINTS

- Depression is associated with increased threat- and loss-focused thoughts and reduced positive thinking and behavior.
- Many of the things that make us feel good in life are associated with the quality of our relationships and, when we are depressed, we often experience some of our relationships (e.g., with parents, friends, work colleagues or bosses) as unhelpful – being too distant or too critical.
- Vulnerability to depression might arise because we carry a number of latent negative beliefs/ideas/views/memories about ourselves (e.g., as unlovable or a failure). We often develop these in childhood.
- These basic beliefs can become reactivated when threatening or loss events happen to us. As a result, we tend to explain or interpret the reasons for the negative events with our negative beliefs e.g., 'This relationship broke up because of me. I am unlovable.'
- Many things that depress us can relate to conflicts we are having within ourselves, with others or over what to think, say or do. We can get stuck not knowing what to do and recognize there are benefits and losses in whichever way one moves.
- It is often our social roles that give us a sense of self-esteem, and not having a valued social role can be depressing.
- Social environments can do much to help or hinder our goals and pursuit of meaningful social roles.
- Depression is never about personal weakness or inadequacy, although we might think so. It is about how our systems have become overstressed and exhausted, leaving us feeling defeated. It is the brain state and pattern in us.

The relationship between our thoughts and feelings in depression

This chapter explores how our thoughts and feelings are often linked together, and how together they can push and pull us down into depression. Cognitive behavioral therapists argue that when events happen to us, or some feelings and thoughts arise in our minds, we also decide what they mean. The meanings we give to things and dwell upon can deeply affect our well-being. One way of looking at this is to distinguish the event that might stir feelings in us from the meanings we give to them. We can explore this by setting it out in three columns:

Events

Nothing happened

Thoughts

Physical reactions

Suppose a good friend promises to phone you at 11 p.m. and asks you to wait in for the call, but then the time comes and goes and there is no phone call. What are the various possibilities for the consequences – what might you feel? Well, you could feel many things: anxiety, anger, sadness or even relief, and you would be absolutely right to say that it all depends on what you think the reason is for the person not phoning. That's the point. We can see this below using the three columns again.

Events

Something has happened to him/her – maybe an accident.

S/he went to a party and

Anger about me.

S/he doesn't care enough

Sad to remember.

S/he will phone tomorrow

Calmer to get to bed now.

Automatic thoughts and feelings

In the above example, the negative emotions of anger, anxiety or sadness indicate that the lack of the phone call is taken as some kind of threat. Jumping to the conclusion that, for example, your friend has had an accident is called an 'automatic thought' or 'automatic reaction'. You can't know what has happened, or the reasons

why she didn't phone, until you have the *evidence*. At this point our thoughts are guesses or theories. Nonetheless, you may feel anxious or worried. As the term implies, automatic thoughts are those interpretations or ideas that seem to come automatically to mind; they are our 'pop-up' thoughts. They are immediate, consciously available thoughts that require little or no effort and can seem plausible. They are not arrived at through much in the way of reflective reasoning. They will often flush through our bodies with feelings; as if we are riding on a wave of feeling.¹

Let's consider these thoughts a little more, this time using the example of anger over the missing phone call. The first thing to note is that you probably don't often think in *words* like, 'Oh, I think my friend has gone to a party and has forgotten to ring and left me waiting in for the call.' More likely, you have flashes of pictures in your mind. If your first flush was anger, how would you answer these questions: Is she having a good time? Is she talking with other people? Is there music playing? Is it classical or disco music? I would imagine that you can answer these questions fairly easily.

Sometimes automatic thoughts are difficult to catch because they happen quickly or are not in full consciousness. Had I not asked you about the party, those thoughts might have gone relatively unnoticed or been only semi-conscious, but when I drew your attention to them, you may have become aware that you had had them. *Sometimes, when we feel a change of emotion, we have to focus on our thoughts and what is actually going through our minds.*

It is common for automatic thoughts to occur in images, daydreams and fantasies. As in the example above, we may construct scenarios of seeing the friend in some particular place (e.g., the party) and imagine her having a good time, laughing, drinking and so on. We may also enter into a kind of discussion with ourselves as a result of our automatic thoughts and fantasies. For example, having decided that the friend is out having a good time while you are waiting for her call, you may start to rehearse in your mind an argument or what you intend to say the next time your friend does phone. You might even rehearse something that you know, in reality, you would not do because of fear of being rejected/disliked, or because of moral concerns.

Sometimes we may not be fully aware that we are constructing such scenes in our heads. For example, when the phone doesn't ring, you may find yourself becoming more sad or irritated, but your awareness of your thinking processes may be hazy. Sometimes we let the scenes in our minds run on, as if there is some 'inner director' in our heads feeding our minds various ideas and pictures that are full of meaning. Hence, we may need to train ourselves to sharpen the focus of our automatic thoughts and make them more easily known, recognized and challenged. We may need to use active imagination – that is, to allow ourselves to tune into the thoughts so that we can examine and deal with them more easily.

Here is a question for you. If you focus on those thoughts and play those kinds of scenarios in your mind, which brain systems are you stimulating? Is that helpful for you?

One thought leads to another

You may have noticed something important in the examples given above – one thought leads to another. Humans are highly creative in their thinking, and we are

usually not happy with just one or two thoughts. At times, especially when we are heading into a depressive spiral, our thoughts spin down into catastrophes. Our threat system is in the driving seat. For example, let's consider how someone heading into a depressive spiral might think about the friend who didn't phone. The sequence of thoughts might go like this:

He hasn't phoned.

This is because he has forgotten about me.

Maybe he had better or more fun things to do.

If he cared about me, he would have phoned.

Therefore, he doesn't really care.

I don't ever seem to be able to find someone who cares about me.

What's wrong with me?

Maybe I am just too boring and unattractive.

I'll never have a good, long-lasting relationship.

I'll always end up abandoned.

Life is completely pointless and empty.

This cascade can be so rapid that we hardly notice it. Rather than just being disappointed or slightly irritated by the phone not ringing, we end up feeling much more depressed because we become focused on being boring, not cared for, are going to be abandoned or are being used by others. When we enter into depression brain patterns, we often experience rapid cascades of thoughts like those above. One reason for this is because *our threat-protection system is hypersensitive and always goes for 'assume the worst' and 'it is better to be safe than sorry' while our rational and soothing-reassuring systems struggle to keep a perspective or help us calm down* – and we will explore what to do about it shortly.

Sometimes it is what we feel within our bodies that generates negative thoughts. For example, people who have panic attacks may notice that their heart rate goes up when they become anxious. This leads to the thought: 'There must be something wrong with my heart for it to beat like this.' They then focus attention on their heart rate, and because they are thinking that there is something wrong with their heart, they become more anxious. And, of course, as they become more anxious, their heart rate goes up even further. Even though the heart is basically a pump and is designed to increase and decrease its beating as circumstances require, the idea that an increased heart rate signals an oncoming heart attack produces an intense anxiety spiral (Figure 6.1).

Hence we can see that we can have negative thoughts about ourselves, others and the future, all of which can increase our depression, and that these can be sparked off by events, our inner feelings, things we notice in our bodies or past actions.

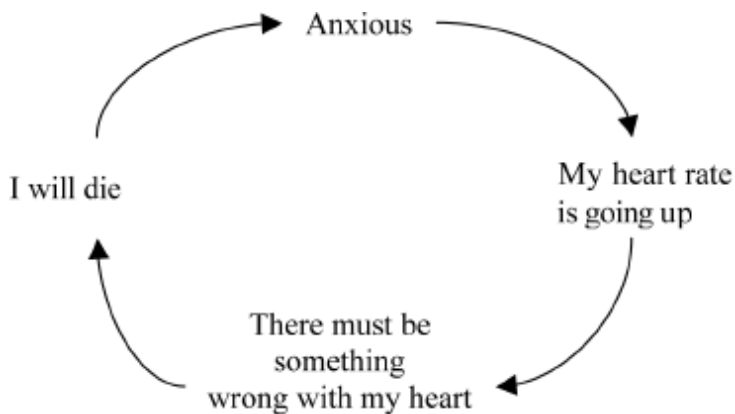


Figure 6.1 How thoughts and feelings interact.

Downward spirals and emotional amplifiers

Usually thoughts like these provide feedback for each other. For example, when we are depressed we often don't feel like doing much; when we don't achieve much, we may tell ourselves how useless we are or feel unlovable or defeated because we are depressed and ratty, which increases depression; we feel depressed about being depressed (Figure 6.2).

You can probably see that if we are caught up in understandable spirals, it can be difficult to get out of it, unless we take steps to stop them. These thoughts might be called *emotional amplifiers* because, as they go around and around, they become more intense. There is nothing in the spiral that damps them down. You need to build in *emotional dampeners* – ways to break the cycle. You may also see that there are some key links in this spiral that you could challenge. You might 'mindfully' accept your depression as your current state of mind (see Chapter 7), which is not your fault, and be kind to yourself. You could do a little bit of some activity and then give yourself a lot of praise for doing something even though you're depressed (see Chapter 12). You know praise will stimulate your positive emotion systems, so you can learn to praise your efforts rather than the results. Think about how you would speak to a friend in the same situation and treat yourself the same way (see Chapter 9).

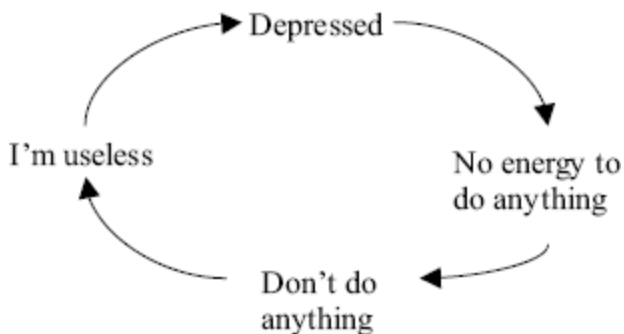


Figure 6.2 How thoughts and behaviors interact.

If you are depressed, don't be surprised if these suggestions don't impress you. You can be expected to discount them – after all, you feel depressed, and that's what we tend to do when we are depressed. We stick rigidly to what we think and the way we see things. A thought to keep in mind for later is to consider whether your feelings of being useless or unlovable are related to frustration and anger about being tired, and you then direct these feelings at yourself, or whether you might actually be frightened to see that you are better than you think you are.

Thoughts about feelings

Although it is often situations and events that spark off threat-related thoughts, this is not always so. Our moods can set us up for certain types of thought – we think differently when in a depressed, anxious, angry or happy mood. Sometimes our feelings can be triggered by things of which we are not fully conscious.² Importantly too, we can have inner feelings such as anger or feeling trapped and then have thoughts about those inner feelings. For example, you might think it is bad to have intense feelings of anger. Or you might have sexual feelings about someone and feel very guilty because you tell yourself that such feelings and fantasies are bad. Or you might feel anxious about something and then think that you are stupid or weak for feeling anxious. You may wake up *feeling* tired and think, 'Oh, God, another bloody day! How am I going to get through it?'

When depressed we can have all kinds of beliefs about some of our own inner feelings. For example, we may believe we have fantasies or feelings that other people don't have. These may be related to frightening, escaping, sexual or aggressive fantasies. We feel we can't talk about them because people will regard us as odd.³ But of course humans have had these thoughts and fantasies for millions of years, and when it comes to frightening, defeatist, sexual or aggressive ones some people write books about them and make a lot of money! They may be pretty horrible fantasies, but they are not abnormal. People may believe that their feelings will overwhelm them. Of course feelings can be very powerful at times, and we need to learn how to tolerate them without acting them out. Stories and films like *The Hulk* appeal to us because we have all had the experience of feeling high levels of rage, which can frighten us. Sometimes it is sadness, tearfulness and grief that depressed people feel they are overwhelmed by, and sometimes they try to avoid feeling. Sometimes depressed people can have conflicts with those they love, and they may believe that this means there is something wrong with their relationship. They may believe that if you love somebody you should never feel very angry or want to leave them.

So it is not just things that happen in the outside world that can worry or upset us. It can also be thoughts and feelings that come into our minds, which we think indicate something bad about us, that can also be distressing. Learning how to cope with our own minds, and realizing that a lot of what goes on in them is because of how our brains evolved, and is not our fault, is important. You have the capacity for intense anxiety, rage or grief because your brain has been built to have those capacities; and you can read about them in novels and see them acted out in films. We have to learn how to cope with strong feelings, what they mean and how they can

blend together; but not blame ourselves for having them.

So you see we can have feelings about feelings. We can become anxious about being depressed, depressed about being anxious, angry about being anxious, anxious about being angry – and round and round we go.

Thoughts and behaviors

We may also have negative thoughts about what we have done or failed to do. For example, because we are anxious, we might not go to a party or some other function to which we have been invited. We might then think that we have behaved badly and let other people down. We become preoccupied with guilt. For example, because he suffered from social anxiety, Colin did not go to a friend's leaving party at work. He had the following thoughts:

I should have gone.

I've let my friend down.

He will be angry that I didn't go and will lose interest in me.

Others will wonder what's the matter with me.

I have missed out on a good time again.

I'm useless in social situations.

I'm pathetic to get anxious.

The more these thoughts took hold, the more anxious and depressed he became.

When Richard looked back at his life he picked out things he felt bad about and dwelt on them. This of course kept him depressed, and stopped him doing anything about them. He recognized that when he was not depressed, he could see his life as complicated and that like all human beings he had made helpful and unhelpful decisions. It is very easy for us to fall into focusing on regrets – 'if only I had or if only I hadn't.' Acknowledging but coming to terms with, maybe grieving for, and moving on from regrets can be helpful to us. We cannot change a single second that has passed, but the future is yet to be written.

Some of the decisions we feel bad about can be major things such as getting drunk and sleeping with somebody we didn't want to, or staying in or pulling out of a relationship and then regretting it. As we will see later in this book, it is important to learn to become kind to ourselves and balanced in our thinking about things in our lives we are not comfortable with, or are disappointed in ourselves about. Very few of us get through life without making mistakes and having regrets. It is how we think about and deal with those things that is important for either learning from them or getting lost in depression over them. Depressed people often are not just unhappy with their behaviors but tend to judge *themselves as a person* rather negatively. We will address these issues in Chapter 13 on self-bullying and Chapter 17 on shame.

Writing down your thoughts

In Appendices 1 and 5 you will find a form where you can write down automatic thoughts, similar to the one we used with the phone call example on page 96. Turn to

the appendix quickly and have a look. In this form you will see that, in the first column, various things can spark off negative thoughts and lead to various negative evaluations and conclusions. You can include events such as people criticizing you or things not working out as you would like (such as not receiving the phone call). We can also make negative evaluations of our *feelings* (e.g., I am a bad person for feeling angry; it is wrong to feel sexual attraction towards someone else who is not my partner), our *behavior* (I should not have acted like that; I am a bad person for losing control) or our *bodies* (when my heart rate goes up, this means there is something wrong with it and I might die). Then you can fill in the other two columns as before, that is, the beliefs and key thoughts of the ‘triggering’ event and its consequences.

The key thing is to choose what you want to focus on, then write down the thoughts that go through your mind. If you habitually write these down, you will get better at identifying them. Writing thoughts down helps to clarify them and allows you to concentrate on them, thus avoiding having them slip in and out of your mind in a rather chaotic fashion. A good way to start is to notice how your moods and feelings change. Try to remember what might have been happening to you at the time your mood dipped or you had a flush of unwanted feelings, or unwanted thoughts popped into your mind – for instance, a criticism, or something that did not work out as you wanted it to, or something you hadn’t done or thought you ought to do. Next, write down the thoughts associated with these situations. Sometimes you will not be able to identify specific things, so just write down thoughts that seem associated with difficult feelings.

Stop reading for a moment and see if you can think of a situation that made you upset recently. Try to identify your thoughts and interpretations that went along with those feelings. Practise this on a few events that you can remember happening to you recently. Gradually you’ll get the hang of noticing that when something happens that makes you feel upset, the upset feeling goes with a set of thoughts about yourself, others, and the world or your future. You are learning that you can have thoughts but you can also stand to the side of them, look at them, understand what they are, and coolly write them down. Over time you can learn to monitor these thoughts as they occur. You can even make a judgement about them that says ‘Although they may be understandable, they may be too influenced by the emotions I am in right now so I need to stand back and give myself some space’ or ‘Dwelling on those thoughts is unhelpful to me so I need to work on this’.

Another useful way to begin is, if you notice a change in your feelings, or even if you notice that you are feeling something that you can identify as anxiety, depression or sadness, ask the question: ‘If my feelings could speak, what would they say to me?’

You will notice that there is a fourth column for writing down alternative helpful thoughts. Some worked examples are given for you. As you go through this book, you’ll get better at identifying what goes through your mind and noting your own depressive spirals (and emotional amplifiers). You’ll also be able to stand back from your upsetting thoughts and not let that ‘better safe than sorry’ and ‘assume the worst’ type of thinking run away with you. It takes time and practice. The way we stand back and learn to generate alternatives, and learn to generate a kind voice in our head when we are suffering (instead of the harsh, frightening or critical one), is what we will explore in later chapters. The first steps, however, are about learning that our feelings and moods come with ways of thinking about ourselves and the world, and

our ways of thinking bring up feelings and moods.

How to identify your thoughts

Sometimes it is difficult to know what are the main worries from our threat and self-protection system. Well, one way is to ask ourselves some questions. For example, let's suppose that you tried to do something and it did not turn out right. You feel disappointed and your mood takes a dip. You could then ask yourself:

~~Questions~~ fears and threats

~~What do I think are the implications of this event?~~

~~What conclusions am I drawing from this situation?~~

You can also ask questions about what you think others will think or how they will react.

~~What do I think they would think about my failure?~~

Another set of questions asks you to think about the conclusions that you might be drawing about yourself as a person. Ask yourself:

~~Why does this say about me?~~ Inadequate.

~~What do I think this means for my future?~~

In general, there are three basic types of question to ask yourself. These are:

- 1 **Questions about how you think others see or think about you and how they will be with you as a result.** These questions are focused on the *external world* and on other people in it. Notice here your attention is outside of you – on thinking about other people – trying to work them out or what you need to do to make them like you.
- 2 **Questions about how you see yourself as a person.** These questions are focused on your *internal world* – on yourself. Notice your attention is turned inward on you this time – on your sense of yourself and on your feelings.
- 3 **Questions about implications, including for the future.** These questions are focused on your *goals and things you want to happen* and possible blocks to them.

So then, if we take our example of 'trying to do something that does not go well', we might have a set of thoughts that are something like this:

EXTERNALLY FOCUSED THOUGHTS

- Other people will think I am not capable of much.
- They will be critical.
- They will distance themselves from me, not want to include me or even reject me.

INTERNALLY FOCUSED THOUGHTS

- I don't have what it takes to succeed – may be inadequate – not the 'right stuff'.
- I will lose my confidence and be anxious.
- I feel depressed/angry/fed up – life is a pain.

FUTURE-FOCUSED THOUGHTS

- I am not going to succeed in what I want to achieve.
- I will be stuck and not go forward as I want to.
- Life will be miserable or pointless.

If these seem like your thoughts, then see that they are the thoughts of depressed minds – all over the world. This can help us stand back and realize this is *depression thinking in us* and these thoughts can change when our mood changes. I am not saying your thoughts ‘cause your bad feelings’, because it’s a little more complex than that. However, by looking at our thoughts *we have a window* on what’s going on in our minds. We can see that the frustration of not succeeding doesn’t stay at that level of a mild annoyance but (in this example) has rippled out to be more intense and create a sense of an inadequate self, a self we don’t like and that isn’t going to be able to do much in the future! It is these ripple effects in our thinking that contribute more depression. When we are stressed our threat systems are super-sensitive and these ripple effects are very common. Therefore we must take steps to work with them. These thoughts might not have been obvious before we asked ourselves the questions. Moreover, taking the time to consider these questions allowed us to focus on our thoughts. By asking certain questions, we can get some insight into what we think about certain situations and events.

Basic beliefs and attitudes

You may well ask: where do these negative feelings and thoughts come from? One answer is that they are generated by the state of depression itself. However it is also often the case that automatic thoughts are generated from the various attitudes and basic beliefs we have about ourselves, others and life in general, and these often predate the depression (see pages 74–83).¹ They include such beliefs as:

- If people make mistakes, they are inadequate.
- People who show strong anger are unlovable.
- You can never be happy if you do not have a conflict-free, close relationship.
- If you have strong arguments with someone close to you, they don’t love you.
- If your parents did not love you or treated you badly, you are unlovable.

There are many types of attitudes and basic negative beliefs like these that tend to lead to negative conclusions. In my own case, I was bad at English and I developed the negative belief: ‘Being poor at English equals being stupid.’ When I was depressed, this belief seemed very true to me – and I therefore felt not very bright or able. When I noticed poor spelling in my work, or I was criticized for my poor English, I would have a particularly uncomfortable ‘sinking feeling’. It was only later that I realized that this belief (‘I am stupid’) was untrue and that I only applied it to myself and not to others, but that’s the way with basic beliefs – we often don’t realize that we have them. It is how our feelings react to certain situations that tells us that we should be alert to the possibility that we may have some basic negative beliefs that need identifying and changing.

Let’s take this back to our three circles that we saw on page 17. Why does being bad at English, or even being not that bright, feel important? Because it is associated

with other experiences such as rejection or criticism. As I have mentioned before, humans have evolved to want approval from others (the pats on the head and smiling faces) because if we feel accepted and wanted we feel safe. It's all about threat and safeness! It is the association of an element of ourselves with the threat of criticism or put-down and thus rejection, or inability to reach our valued goals, that causes the problem. If you are overweight, or struggling at any activity, you're going to feel a lot better if you know people will not judge you negatively but will accept or love you, and help you. Indeed, in some societies women *put on* weight because that is deemed attractive! So if we do not do so well, somewhere in our minds can be feelings of shame or of being seen as different from others in some way, that gives us a sense of aloneness. This is the basis of a sense of threat in these situations. And it is because this threat underlies many of our negative thoughts and beliefs that learning to be kind and compassionate is so important. It will help us settle our threat systems.

Let's get back to basics. As a rule of thumb, threat-focused automatic thoughts are triggered by situations or things that arise in our minds at specific points in time. They may often include basic threat-focused beliefs, some of which are like our basic views about life. They too can be internally focused on the self or externally focused on others, and some will be focused on life goals. We had a look at some of Sally's beliefs in Chapter 5 – now let's look at them again in a more complete way, in Table 6.1.

TABLE 6.1 INTERNALLY FOCUSED BELIEFS		
About the self	About others	Future and goal-focused beliefs
I am a nuisance to others	Other people are easily upset and become critical	I am unlikely to get the confidence to do what I want in life
I stop people doing what they want to do	Other people are more powerful than me and can hurt me	My future is really dependent on how I get on with others
I must not do anything that could push them away	People don't really want me around	
I must be to others what they want me to be	Other people won't tolerate or try to understand my feelings	
Expressing anger and/or asserting my needs could lead to rejection	Other people may act nice but they think different things underneath	
I must be grateful for love	Other people think I am deficient in some way	
I am a bad/ungrateful person if I express my dissatisfactions		

Although these thoughts and beliefs were not active all the time, it did not take much to trigger them. Keep in mind too that it is not just beliefs that are triggered, but emotional memories associated with where Sally learned those beliefs. For example, the idea that expressing anger leads to rejection will be associated with emotional feelings and memories of rejection. The beliefs and the feelings that come with them together form a tight tapestry of experience. The beliefs are the verbal descriptors that shape meaning. Can you see how Sally's threat system and feelings of insecurity might be at the root of these difficulties? Can you see how her beliefs are like warnings and things that are frightening to her – they are sort of 'better safe

than sorry'. If you assume that other people see you as deficient, then you can try to protect yourself – so better safe than sorry.

Dwelling on thoughts

When we dwell on something, we turn an idea or set of beliefs over and over in our minds. This is called *rumination*. A common situation is to lie in bed and worry, your mind focusing on a particular train of thoughts. This is not the same as having an immediate reaction to something and then pulling back and seeking out the evidence. When we dwell on things, we are allowing ourselves to think along a certain path for many minutes or even hours. Depression involves not only automatic thoughts and immediate reactions to situations, but also ruminating, dwelling on the same negative thoughts. This type of thinking is important to recognize and interrupt.

Remind yourself about the three circles in Figure 2.1 on page 17, and also remind yourself about the way the thoughts and scenes we run, and go over in our minds, stimulate our emotion systems as discussed on page 28. Dwelling and ruminating is very easy, it's like letting the wind blow you along. The problem is although the wind is strong, you might be sailing in the wrong direction! Think about what dwelling on negative things does to your brain; think about the systems you are stimulating when you dwell on the threat and loss. This is not a criticism, because our threat system will hold you in the negative, because it's focusing on threat and protection – which is what it is designed to do. It is not bad, or your enemy, but we can appreciate it's actually taking us in the wrong direction. Our goal is to stimulate the positive emotion systems – to work towards our well-being. We want to calm the threat system, not keep it turned up. That's why we need to learn how to refocus on kindness, getting a wider perspective and standing to the side of these distressing or angry thoughts. The practice of mindfulness, of (just) observing our thoughts without engaging with them and/or of deliberately shifting to compassionate imagery and thinking can be helpful, and we explore that in our next chapter. We *need to make efforts* to create a warm and kind voice that is understanding about our pain when we find ourselves ruminating.

By now, you will probably be aware of the kinds of things you dwell on. These may be thoughts of inadequacy, injustice and unfairness, revenge, loss, and/or negative predictions of the future – in fact, just the kinds of thoughts that everyone has from time to time. Become more aware of any common 'themes' in your thoughts. If you find it difficult to recognize when your mind is dwelling on things, you can leave notes to yourself around the house that remind you to check on what you are thinking. Or you could carry a small object such as a stone in your pocket so that, each time you feel it there, this will be a signal to check on your thoughts. If you have been dwelling on certain things, gently remind yourself that you can break off from these thoughts. Indeed, do whatever works for you to help yourself from dwelling on negative thoughts and indoctrinating yourself with them.

KEY POINTS

- When something happens to us, we often have various thoughts about what the event means to us. These are our interpretations and they are personal to us.
- These thoughts can be automatic and just pop into the mind.
- One automatic thought can lead to another and spiral us down into deeper, more depressed feelings.

- We can have negative thoughts not only about particular situations but also about our inner feelings, fantasies and past actions.
- Our thoughts can be difficult to pin down, but if we ask ourselves certain types of questions, they might become clearer.
- We may ruminate and dwell on unpleasant feelings, thoughts and ideas, and so spiral down into deeper, more depressed feelings.
- We often need to train ourselves to become more aware of our automatic thoughts and the themes we tend to dwell on.
- One way to begin to gain more awareness of your thinking is to make a habit of writing down your thoughts.
- Some of our negative automatic thoughts are triggered because we have underlying basic negative beliefs. Until we recognize our automatic thoughts, we may not be aware of these basic beliefs that could be guiding our lives.

EXERCISES

Exercise 1

At first, you might use a notebook that you keep handy. Draw up three columns that allow you to separate out triggering events, beliefs and key thoughts, and feelings, and then stand back and refocus on helpful, compassionate thoughts and feelings.

- Write down whatever comes into your mind – even if, at first, it does not make much sense.
- Start to consider your thoughts when your mood changes. Learn to ‘catch’ your thoughts. Give yourself time and space to focus on them.

Exercise 2

To gain more insight into your thoughts, ask yourself some questions. These can include:

- Questions about how you see yourself as a person.
- Questions about how you think others see you.
- Questions about implications, including for the future.

Exercise 3

Use or make copies of the thought monitoring form (see Appendices 1 and 5), familiarize yourself with it, and try using it. As you become better at catching and noting your thoughts, work on the fourth column – creating and generating compassionate, helpful alternatives to your thoughts. We will be exploring how to do this in a lot of detail in the chapters to come, but you already have some ideas such as trying to create a compassionate point of view in your mind.

- Watch out for threat-focused thoughts that are frightened to try or that always focus on the ‘can’t do’ rather than “Maybe this won’t help, but what have I got to lose from trying?”

PART TWO

Learning How to Cope: First Steps

Mindful preparations for working with depression

Your journey journal

We have now arrived at the *work* and *practice* part of our exploration together. You might find it helpful to have a folder or a journal that you keep to write in reflections on different exercises, or thoughts you've had during the day, or ways in which you might respond to things differently, or even note changes in your dreams. It's like a personal log. You can also gather things along the way – pictures, poems or articles – to stick in it. We know that writing about our thoughts and feelings reflectively can be very helpful to clarify them and can also provide insights. You will find there will be some days when you may want to write in your journal and other times you may not. Having a journey journal is, of course, only a suggestion, although I will be inviting you to use it in different ways as we go along.

First steps: mindfulness

On the road ahead we are going to explore how to work on thoughts, feelings and behaviors, to change depressed brain states. One of the most useful skills to help us in all these efforts is called *mindfulness*.¹

In recent years researchers all over the world have dedicated a lot of attention to mindfulness and how it can help depressed people, and indeed all of us.² The idea of mindfulness itself goes back thousands of years. Here we focus on mindfulness as *a way of learning to pay attention, and hold attention in the present moment with a specific focus and with judgement*. This it can bring new balance to our minds and awareness.³

Many of the great teachers of meditation point out that we only exist in *this moment* – we are a 'point of consciousness' passing through or in time. Our consciousness does not exist in the moment just gone nor in the moment yet to arrive – we only exist *now*. Mindfulness is learning how to bring us to be fully alive to the *now* of our conscious existence, the only place we actually exist. We can be so lost in the hopes or fears of tomorrow, or the regrets of yesterday, that we miss the moment *now* – we live in a remembered or imagined world, not in the world of 'right now'. Of course, sometimes it is very important to reflect back and project forward, but when we do this we want to do it purposely rather than being automatically dragged there by depressed states, fears, angers or strong desires.

The word *meditation* actually means *becoming familiar*. For us becoming more mindful is to become familiar with the contents of our minds and how our minds

work. Mindfulness also means becoming more aware and more ‘in’ one’s experience; to pay open or curious attention to the details of one’s inner feelings and thoughts as they emerge in one’s mind. How many of us, for example, when anxious or angry, actually stop and pay attention to where this feeling is in our bodies, what our voice sounds like, what part of our mind is now issuing the instructions to our thoughts and bodies; what are our key thoughts and fears? How often do we stand back and practise *observing* what is actually happening in our minds? Mostly we don’t, and our brain patterns and emotions are just ‘doing their own thing’. Mindfulness is learning how to change this ‘being caught in the automatic-ness’ of the unpleasant emotions and moods.

Yourself and consciousness

Let’s think about ourselves as existing as *a point of consciousness* ‘in this moment of time’. Consciousness of this type can be regarded like water. Water can contain a poison or a medicine, can be clear or muddy – but water is water – it is pure *and is not what it contains*. So too with our consciousness – it can be filled with joy, anxiety, anger or depression but consciousness itself is not those things. Learning to recognize yourself as a point of consciousness and distinguish this from the content (your moods, feelings and thoughts) can be helpful. A key to help us is learning about our attention.

Learning to attend

Mindfulness is a way of understanding our attention. The attention can be located as an act of choice. For example, if I ask you to concentrate and attend to the big toe on your left foot, you will suddenly *notice* sensations from that part of the body. If you now switch your attention to the top of your head, you will experience different sensations. Our conscious attention can be thought of as a spotlight that moves around. It is learning how to direct that spotlight, via our attention, which is key to mindfulness.

Mindfulness is therefore about the clarity of observation. Let’s try an example of eating an apple mindfully. First, you would look at the apple, and note all of its colours and textures. Hold the apple in your hand and feel the quality of its skin. Don’t rush, spend time observing. When your mind wanders from your focus on the apple (as it very easily can), gently bring your focus back to it. In this exploration, you are not judging the apple, you are simply exploring its properties. Then you take a knife, and maybe peel the apple, or cut into it. Once again, notice the effect that you have on the apple, the colour and texture of the fruit beneath the skin. Take time to really observe. Next, you may take a bite of the apple, and now you are going to focus on the senses of taste and what the apple feels like in your mouth. Chew slowly, feeling the texture in your mouth, noticing how the juice might stimulate your saliva and how it feels in your mouth. As you chew, notice how it becomes more mushy. As you swallow, pay attention to the sensations of swallowing. All focus is on the apple.

So we have explored the apple visually, by touch and feel, by smell, texture, and by taste. If we had dropped the apple, we would have been able to hear what it sounded like. In this interaction, there is *no judgement*, there is *only your experience of your interaction with the apple*. This is mindful attention, being in the activity,

rather than distracted from it by other thoughts, and exploring all aspects of the activity to the full.

Notice how your mind can wander: ‘These are not good apples, where did I buy them from; I ought to eat more fruit; actually I don’t like apples! Oh damn, I cut my finger!’ If you are depressed you might have thoughts like, ‘What is the point of this, it doesn’t solve my problems’ – thoughts that will put you back into stimulating depressed patterns in your mind. One reason for doing these exercises is to practise shifting out of patterns of thinking and focusing that increase rather than diminish depression in our minds. The mind can ‘rest’ in this moment.

Mindfulness is important because most of our lives are spent doing one thing and thinking about something else, and we are never fully ‘in this moment’. Our minds are constantly distracted. Take driving, for example. We can get home and realize we can’t really remember how we got there, because our minds were full of a hundred and one other things. If something unexpected happened, such as a group of naked motorcyclists zooming past us, our attention would have been alerted, or if the driver in front of us suddenly put on their brakes, our attention would be focused again. But this is not *savouring* the moment; this is being brought to alertness for a specific reason. Mindfulness is about being in the moment.

Soothing rhythm and mindful breathing

We are now going to use the same idea as mindfully peeling and eating the apple, but this time focusing on our breathing. Our breathing will become a central focus around which we will do some compassion-focused exercises later. Learning how to breathe mindfully will be useful when we come to do these exercises. The key here is simply to practise without worrying if you are doing it right, correctly, adequately and so forth. These thoughts are common and understandable but they are distractions. If they arise in your mind, simply notice them and call them ‘your judging and evaluative thoughts’, *smile* kindly to yourself and bring your attention back on task.

To start with, find somewhere you can sit comfortably and won’t be disturbed. Place both feet flat on the floor about a shoulder’s width apart and rest your hands on your knees. Keep your back straight. Look down at about 45 degrees – or if you prefer close your eyes – whatever you find best for you. You may prefer to sit on the floor, or cross-legged on a small meditation stool. Find postures that are comfortable for you but not slouched. Sometimes lying flat on the floor can be helpful, if that is the most comfortable position for you to start your work. In my CD, which covers aspects of this book, there are ideas that you can listen to.⁴ The idea is not to become sleepy but to develop a certain type of alertness, focus and awareness. I will, however, explore a set of relaxation exercises with you later in this chapter.

Gently focus on your breathing. Breathe through your nose. As you breathe in, let the air come down into your diaphragm – that’s at the bottom of your ribcage in the upside down V. Place a hand on your diaphragm and notice your hand lift and fall with your breath. Feel your diaphragm – the area underneath your ribs – move as you breathe in and out. Do this for a few breaths until you feel comfortable with it and it seems natural and easy for you. Next place your hands on each side of your rib cage, as low as you can. This is slightly more awkward because your elbows will be pointing outwards. Now breathe gently. Notice how your rib cage expands against

your hands outwards, your lungs acting like bellows. This is the movement of the breath you're interested in; you feel your lungs expanding. You want a breath to come in and down but also expand you out at the sides. Your breathing should feel comfortable and not forced. As a rough guide, it's about three seconds on the in-breath, a slight pause and three seconds on the out-breath. But you must find the rhythm *that suits you*. As you practise, replenish most of the air in your lungs but not in a forced way.

Notice your breathing, and play around and experiment with it. Breathe a little faster, or a little slower, until you find a breathing pattern that, for you, seems to be your own *soothing, comforting rhythm*. There will be a breathing rhythm that feels natural to you, and as you engage with it feel your body *slowing down*. It is as if you are checking in, linking up, with a rhythm within your body that is soothing and calming to you. You are letting your body set the rhythm and breathe for you, and you are paying attention to it. Rest your eyes so that they are looking down at about 45 degrees. You may wish to close your eyes, but notice that sometimes if we do that we can become very sleepy. Spend 30 seconds or so focusing on breathing, noticing the breath coming through your nose, down into the diaphragm, your diaphragm lifting, your chest gently expanding sideways, and then the air moving out, through your nose. Notice the sensations in your body as the air flows in and out. Stop reading this book, and focus on that for 30 seconds (longer if you like) and sense a slight slowing with your breathing. Some people find that focusing their attention on just the inside of their nose, where the air comes in, can offer a helpful attention focus. Try it and see.

You might notice how your body responds to this breathing, with feelings of slowing and feeling slightly heavier in your chair. If you've done the exercise you may notice how the chair is holding you up. However, some people can find these first stages quite anxiety provoking, and don't actually like them. For those who do not like the breathing bit, you can practise mindfulness by holding your attention on something in the way we did above with the apple; choose something like a flower, a tree or the sky. Hold your attention there and if your mind wanders, gently and kindly bring it back. Don't worry at all if you find the breathing tricky (many people do) and we can do the compassion exercises in later chapters without doing the mindfulness breathing. Nonetheless, it could be useful to practise, so that even if you can only do a few seconds and gradually expand over the days that would be helpful too. The sensations in the body can be difficult for some people – so practising and coming to feel comfortable with the sensations can help.

Wandering and grasshopper mind

Assuming all went well, you may have noticed that actually, although it was only 30 seconds or so, your mind may have wandered off. You may have had thoughts like 'What's this about? Will this help me? Did I do my job correctly yesterday? Where did that pain in my leg come from?' If you practise for any length of time, distracting discomforts are very common. You may have heard various things outside the room; your attention may have been drawn to the postman pushing letters through the letterbox, the traffic outside or whatever. The point about this is that our minds are indeed very unruly and the more you practise this short breathing exercise and the longer you extend it, the more you will notice how much your mind simply hops

about all over the place. When you first do this kind of mindful focusing, it can be quite surprising how much your mind does shift from thing to thing. This is all very normal, natural and to be expected. We need to train the mind, and the only thing that is important in this training is *not to try to create anything*. You are *not* trying to create a state of relaxation. You are *not* trying to force your mind to clear itself of thoughts – which is impossible. All you are doing is *allowing* yourself to playfully and gently notice when your mind wanders and then with kindness and gentleness bring your attention back to focus on your breathing. That's it. Notice and return. Notice the distractions, and return your attention to your breathing. Notice how often your judging mind tries to get in on the act with thoughts like 'Am I doing this right; is this helping me; am I relaxed now?' Just notice these thoughts and return your attention to the breath. The act of noticing and returning your mind to the task at hand (in this case the breath) *are the first steps to becoming mindful!* In other words, the exercise is simply an exercise where we learn to focus attention. *You are not trying to achieve anything*. If you have a hundred thoughts, or a thousand thoughts, that doesn't matter. All that matters is that you notice and then, to the best of your ability, gently and kindly bring your attention back to the breathing.

If you practise that 'attention and return', 'attention and return', with gentleness and kindness you may find that your mind will bounce around less and less. It may become easier. Remember, *you are not trying to relax* as such. All you are doing in this exercise is noticing that your mind wanders and then return it to focus on your breathing. Notice and return, and each time it wanders, that's fine; don't get angry with it, kindly bring it back to the focus of your breathing. It can also help if you *allow yourself to smile* when you notice the wandering mind. Develop an attitude of gentleness and kindness to your wandering mind.

This exercise of mindfulness is allowing yourself some time where you focus on your breathing and for your mind to come back to that single focus. You may take an interest in how much of a grasshopper (or kangaroo) mind you have, but at all times try not to condemn your wandering mind, always be gentle, always kind. Notice and return. If you have thoughts that you are not doing it right or that it cannot work for you, then note these thoughts as typical intrusions and return your attention to your breathing.

Some people like to go on and have a focus for their attention, such as a candle or a flower (concentrative meditations). Again the issue here is learning how to enable one's attention to focus, without it being cluttered with various thoughts, reflections, concerns, worries and so forth; or if it is, to notice this as 'thoughts arising'. Another variation is to have a mantra, which is a word or phrase to focus on in one's mind. Some people think you need to be given your mantra whereas others believe you can choose one for yourself such as 'om', 'peace', 'calm' or 'love'. The key word should have meaning for you, and 'feel calming'.

Applying the principles of mindfulness

You can use mindfulness in many different ways. Another aspect of mindfulness is to become more fully aware of each moment we are in. For example, while eating, you may practise really focusing your attention on the taste and texture of the food, chewing and eating slowly. Waiting for a bus or lying in the bath or while out walking, really focus on where you are. If walking, focus on the movement of your

body. Notice how your feet lift and fall in coordinated action; how the foot comes down from heel to toe as it hits the ground; how your arms move and your breathing flows with the action. In mindfulness we can focus on the thought, 'I am walking.' Or focus your attention on what is around you. The idea is to help your conscious mind focus on where you are 'right now' – using all your senses – noticing the colours, the sounds and the textures.

A pleasant place to practise mindfulness is in the bath. Often when we relax in the bath we allow our mind to wander all over the place. However, practise breathing your soothing rhythm and breath and attend to the experience of being in the warm water. Feel how your weight is different, explore from the tips of your toes to the top of your head the warmth of the water caressing your body. 'Be' in every detail of the sensory experience. These exercises can be enhanced if you allow yourself a gentle compassionate smile and facial expression.

Noticing where we are

You may wish to be in the moment in different ways by paying attention to your senses. While out walking, direct your attention and notice the sky – keep the focus there – notice the changing textures of the sky from the horizon to overhead, or the rushing of the clouds, or their shapes or how the light catches different aspects of the clouds; or on the trees with their different shapes, textures and leaf colours, the feel and taste of the air. Again, if the mind wanders, gently bring it back. The very act of seeing colour and hearing sounds, and sensing the air we are enmeshed and live in, can become like new experiences to us, focused on what is around us in-this-moment.

When we get depressed or worried or preoccupied we can withdraw from the world of the senses and being fully in this moment, and become focused on our thoughts about tomorrow or yesterday, or on feelings or feeling states – the heaviness in the body or the butterflies and anxiety of dread. We do not live in the present moment, but somewhere else. When we are on automatic pilot we are lost to our thoughts and we may hardly notice the outside world. There is evidence that learning to be mindful can help depression because it lifts us away from over-focusing on the negative; gives our brain a chance to rest without being bombarded by negative thoughts.²

Developing Emotional Tolerance

We know our minds will give us a range of thoughts, feelings and moods. Mindfulness can help us to become aware of them without forcing them away, being frightened of or fighting with them, avoiding them, or getting caught up in them. We learn to stand back and observe; to take a 'view from the balcony', if you like. If you are feeling sad, be with that sad feeling rather than pushing it away. If you're fretting or worrying over something, notice how your mind pulls you this way and that. In mindfulness we are not trying to change thoughts but *change our relationship* to our thoughts and our feelings.

Jack's suicidal feelings and thoughts had previously worried him, and he would try to put them out of his mind. This of course made them come back even harder. He

learned to acknowledge them and recognize that they came and went from time to time; but it was possible for him to acknowledge them, to stand back from them and become less frightened of them; he noted that he shared these experiences and thoughts with many millions of other people; and he could be compassionate to them. Of course, different people find different things helpful in coping with these thoughts. Some people find distraction works, or talking to others, or reminding themselves that they have had such thoughts before and they passed. And of course if you feel unable to control them, then contact your family doctor.

Karen was, in her own words, a 'fretter'. She learned to pay attention to her thoughts and noticed that they were often full of 'What would happen if . . .?' 'What would happen if I didn't do . . .?' Gradually she learned to stand back from them, became more observant of her fretting thoughts, 'let them be' and found that 'by themselves' they became less intense.

Mindful relaxing

So now we can let be, we can move to another exercise using 'notice and return', but this time we are going to focus on allowing ourselves to relax. I am going to talk about letting tension go, and by this I mean trying not to see tension as a bad thing or your enemy that you have to get rid of, but rather as an understandable way your body has tried to protect you by becoming tense and ready for action. We need to be gentle and help the body understand that it does not need to be like this right now. As we let go of our tension, it is like giving the body permission to relax – for which it is grateful.

You can hear this guided exercise on my CD.⁴ So now once again focus on your breathing until you click into, find, sense, or feel the rhythm that feels most comfortable and soothing to you. If that seems hard, not to worry, just breathe in as comfortable a way as you are able. Spend about 30 seconds finding your rhythm – longer if you wish. When you have done that, focus on your legs. Notice how they feel for a moment. Imagine that all the tension in your legs is flowing down through your legs and down into the floor and away. Let it go on its way. As you breathe in, note any tension and then, as you breathe out, imagine the tension flowing down through your legs and out through the floor. Imagine your legs *feeling pleased and grateful* that they can let go. Imagine your legs smiling back at you. Sometimes people find if they slightly tense their muscles as they breathe in and then relax as they breathe out this can be helpful. Spend 30 seconds (longer if you like) letting that tension go with kindness.

Let's focus on our bodies and imagine the tension in our bodies from our shoulders down to our trunk and again, as you breathe out, imagine the tension leaving this part of your body, going down through your legs, down through the floor and away. Again if it helps, gently tense your stomach and back muscles as you breathe in and then relax as you breathe out. In a way it can be like imagining emptying a vessel of the tension that's now running through your legs and down through the floor. Your body *is grateful* and you feel kind to it.

Focus on the tips of your fingers, through your wrists, arms, elbows and shoulders. Imagine that the tension that was there can be released – can be let go of. Gently let the tension go so that it can run off down through your body, down through your legs and out through the floor and away – free.

Imagine the tension that sits in your head and neck area and forehead. The tension has been your alert system in action, and it would like to be released now – to take a rest. Again, as you breathe out, imagine it running down through your body, down through your legs and out through the floor.

So now you can focus on your whole body. Each time you breathe out, focus on the keyword RELAX. Imagine your body becoming more relaxed. Spend a minute or so doing this (longer if you like). Create a ‘calm’ facial expression.

Ending

You can end this exercise by taking a deeper breath, moving the body around a little and stretching your arms out. Note how your body feels and how gently grateful it is to you for spending time to let go of the tension. Take a moment to experience the idea of your body being grateful to you for spending time with it. When you are ready, get up and carry on with your day. You can practise this exercise as often as you find helpful. It can help with sleep too. Remember that if your mind wanders when you do it, you can gently bring it back to the task at hand – with a slight, kind smile. And of course practice will help it to become easier for you.

Variations

There are many variations on this basic exercise. It’s up to you how you go about exploring different relaxation exercises and finding ones that works for you, or that you like. The one that I’ve given you is one with a mindful and compassionate focus, and helps some people. The idea is to do the practice and then see what happens for you. When you are trying to relax, ‘notice and return’ when your mind wanders from the focus on relaxing. Remember, it’s a bit like sleep: we create the conditions to aid sleep, but if we focus too much on sleep it slips away. The idea is that as you sit there, allowing yourself to focus on your breathing, you may become more relaxed as you become more familiar with your body and the feelings of relaxation; you may become more aware of where tension sits in your body.

Gradually, you can come to think of your body as a friend, and you can become a friend to your body and take an interest in your body and how you can nurture it, care for it and help it relax. Tension is not your enemy to be ‘got rid of’, because it only came as a form of protection and preparing your body for action – so it is grateful for its release from your body. It’s like telling the army ‘the battles are over and you can all go home now’. Focus on the feeling of *gratitude* in your body for doing these exercises. Each time you finish an exercise feel your body’s gratitude for a moment. Developing this attitude to relaxing counteracts tendencies to force yourself to relax, getting irritated if it is difficult, or seeing tension as ‘bad’ and ‘to be got rid of’.

Relaxing in activity

Sometimes people can notice certain feelings in their bodies that are unpleasant and are associated with emotions. Sometimes people find relaxing actually makes them feel more anxious. This is not uncommon. When we are in different mind and brain states, relaxing might be a bit tough. If I am very uptight or agitated about something I find focusing on soothing breathing with *some physical activity* works for me. I might focus my mind on the here and now and engage in soothing breathing but

along with physical activity such as cycling, digging the garden, taking a walk, doing the dishes (okay, emptying the dishwasher) or playing guitar.

Sensory focusing

When Sue Procter and I ran a group for people with mental health difficulties, they found mindfulness and relaxation hard at first.⁵ We brainstormed the issue together and they felt that if they had something they could focus their attention on, other than their breathing and bodies, this might help to get them started. Together we came up with tennis balls to focus on. They would do their soothing rhythm breathing and mindful attention, but focus on holding a tennis ball, exploring its textures and feel in the hand – and yes, it made for some very amusing comments – ‘Hold on to your balls, we are going mindful!’

Grounding

In many parts of the world people have a focus on things like worry beads that are smooth to the touch and can be run through the fingers. When I lived in Dubai in the late 1960s I was struck by how many people used worry beads, with the very clear understanding that these were to help them with attention and staying calm. These beads help to ‘ground’ them, keep their attention focused.

Sometimes people like to ground their meditations or relaxation exercises. You can do this in a number of ways. One is to find a stone you like the look and feel of. As you do your relaxation exercises, hold the stone gently in your hand. Feel it as you breathe. This will help link the feeling of your stone to your state of relaxation. We are going to use the same idea when we look at compassionate imagery in the next chapter. Then later, if you’re feeling tense you can breathe the soothing rhythm and hold your stone, to help ground you slightly.

Another grounding aid can be to use smell. Some people like to associate relaxation and calm with a scent of some kind. Aromatherapists can provide all kinds of smells/scents that are associated with relaxing. If (with or without their help) you find one that suits you, you can carry it with you so that if you want to relax you can engage your breathing and also use your smell/scent. Psychologists suggest that we can prime states if we use multiple senses, such as attention, smell and/or touch.

Another common grounding experience is to gently touch your index finger and thumb together while you’re doing your relaxation exercises. Then when you relax once again, bring your index finger and thumb together. For example, if you were practising your relaxation at work, you can sit with your fingers in that position. Sometimes if we are upset and we want to ground ourselves we can just engage in the soothing rhythm breathing, with index finger and thumb touching.

As with all the exercises in this book, once you understand the principles of what we are trying to achieve (that is to bring some balance to our emotion systems and activate the soothing system in our brains), then look to your own feelings and experience to guide you – try out different things and see what works for you. You have intuitive wisdom; you just need to listen to it.

Keep in mind also that these ways for being with our bodies can also be used when we are engaging in activities. Suppose we have to do the washing up or the ironing: we can practise doing them by working through our relaxing training, rather than being on automatic pilot and ruminating on our difficulties. Developing a

relaxed body is a way of being kind and gentle with it and nurturing it. Sometimes we have to be reminded to do it, so it can be useful to put notes about the place – perhaps behind the sink, or near the bath.

Bring relaxation into everyday life: the chill-out

Being alone

It is often useful to recognize that although caring relationships are very important for us, at times it is important to be alone. Of course some people live alone and feel lonely, but for others it can be hard to find personal space and time in modern houses that are designed as small boxes. And of course the British weather can trap us inside. However, for millions of years we would not have needed to wander far to get away from others. Aloneness as choice is of course very different from loneliness which we do not choose. If possible, get some time alone. I have known some women who feel guilty about this, or for telling the family they need chill-out time alone. One woman noted that even when she went to take a bath it wasn't long before voices would call at her, 'Where are you; where did you put my shirt; Mum, have you seen my homework?' Explain to people that we all need time for ourselves, to chill out, and this is not a reflection at all of not wanting to be with people. The point is to put time aside to be alone and think about how to use that time to *nurture and nourish* yourself.

Chill out in your mind

If you are busy, small chill-outs can be helpful. Keep in mind all the time that what you're trying to do is to stimulate and regulate brain patterns. For example, you get a phone call and someone upsets you. Stop for moment and focus on your breathing. Notice the feelings rippling through your body. Try putting them into words, as research shows that this helps with regulating our feelings. For example, 'Right now my body is feeling tense. I have this tension and butterflies in my stomach, my face is tense, my mind is leaping from one angry or upset thought to another. Okay, let's find the soothing rhythm and reside there for a while. My old brain will be rushing along as it does, but I am going to be with my soothing rhythm for a moment and *watch* my thoughts and feelings go by.' Perhaps you have seen those colourful spiralling patterns that are created on the computer when we play music – it can be something like that. This learning and practice, to stand back and observe our minds, can be very helpful. Shortly we will be looking at compassionate imagery and how it can be added into this work.

In Chapter 4 we noted that we can have many mixed and conflicting emotions all at the same time. If we are rushing we don't take time to pull back from the many feelings swirling around in us. For example, in addition to being angry about something, we might feel sad and anxious. We can engage in soothing rhythm breathing, and pull back from our emotions, become more observant and aware of their mixed and varied textures. As we become more emotionally aware we can learn to recognize these feelings, and even to spot them as they arise. This can be very

helpful because it means we can take steps to help ourselves have more control with feelings.

Mindfulness can be a way of engaging in *all aspects of our lives*. Although it is extremely helpful to have time aside which you can dedicate to mindful practice, it is also useful to bring it to key activities in *all facets* of your life. Mindfulness can help us to enjoy the small things more, to savour our pleasures.

Becoming an alien for a day

There is a rather nice playful exercise that you can try to see if this creates a type of mindfulness for you and new feelings about being alive – this is to imagine becoming an alien for a day. Imagine that you come from a very different planet, maybe one where there is little light and the sky is dark, and you're visiting here. You are fascinated by everything that you see and sense; by the sky and its ever-changing colour patterns, the smell and feel of the air, the sounds around you, the colours of the cars, the trees and the grass. Allow yourself to be amazed and fascinated by the greenness in the living plants and the shapes of leaves. The idea is to playfully begin to experience the world anew; to bring a freshness to our perceptions and senses. I once read about some funny graffiti. Someone had written 'Is there any intelligent life on this planet?', clearly bemoaning some of the silly things we humans do. Underneath someone had written, 'Yes, but I'm only visiting'.

The art of appreciation

If we can direct our attention to where we want to direct it, to the top of our head or to a big toe or to the plants sitting on the sideboard, why not use this ability to stimulate some of our positive emotions? There is an old saying that 'The glass can either be seen as half full or half empty'. When we feel good the glass is half full; when we're feeling depressed we see it as half empty (if we are a bit paranoid, we might wonder who has been drinking our water!). We know that our moods shift our attention. The glass is the same whatever – it does not change – only our feelings and perceptions of it do. But we can also practise learning to shift our attention to the things that we appreciate, things that stimulate pleasures and nice feelings in us; *we can practise directing* our attention to the half-full bit of the glass. Here's how to have a go.

Each day when you wake up, focus on the things that you like or that give you just a smidgen of pleasure. For example, you may have liked being in a warm bed. Rather than focus on how having to get out of bed is annoying, smile to yourself at the enjoyment you have had in being comfortable and warm and in just 16 hours or so you can come back here. Think about how you enjoy the shower or the taste and feel of your first cup of tea, or the taste of your breakfast, or reading the newspaper. When you make your tea and toast, try doing it mindfully. Pay attention to the water, that life-giving fluid, and how it gradually turns brown as the tea infuses in it; notice the toast has got lots of dark crumbs; if you were an ant crawling over your toast it would be a lunar landscape. When was the last time you really tasted fresh toast and butter; I mean took the time and attention and *really* tasted it? Do you know the smell of the air of a new spring day; do you take time to really breathe it, notice it and

appreciate it?

Even doing something mundane such as the washing-up, do you notice the warm feeling of the water, do you notice the bubbles and the way in which you can see rainbows in the bubbles? We lose our fascination because we are a species that easily gets used to things, we get bored and want something new. We're also thinking about so many other things – one of which is that it is a drag to have to do the washing up when we are tired and want to do so many other things – like get back to that warm bed. But learning 'to notice', to feel and to see, can stimulate our brains in new ways.

Appreciating other people

Take time to appreciate what people do for you. Choose a day and spend time focusing only on the things that you like and appreciate in people. The things you don't like you will let go and not focus on. You can do that tomorrow if you want to, I guess. Think about how all of us are so dependent on each other. People have been up since 4 a.m. so we can have our fresh milk, bread and newspapers, and every day they do the same. What about the people you work with? What are their good points? How often do you really focus on those? How often do you make a point of telling people that you appreciate them? What you are doing in these exercises is practising overruling the threat system that will focus you on the glass being half empty. It's what it's designed to do, and what we can so easily be pulled into. So let's start to take control over our feelings and *deliberately* use our attention to practice stimulating emotion systems that we want to stimulate because they will give rise to brain patterns that give good feelings; appreciation is one way of practising doing this.

Sadness

If we are depressed then in becoming mindful we can also become aware of unaddressed issues in ourselves. When people practise mindfulness, it is not uncommon for them to become sad and even tearful because they are now open to unaddressed issues. Once the mind stops rushing from thing to thing it can begin to experience the more subtle levels of itself. For example, Jennifer discovered that working with a compassionate form of mindfulness made her feel sad. Then she realized it touched a part of a memory of the death of her mother five years earlier. In her heart she knew she had been trying to avoid grieving – almost as if, if she didn't grieve, then maybe mum hadn't really died.

So if you have sad or anxious feelings arising in your work, stay with them – be mindful and observant of them, maybe write about them in your journal. If you have friends or a partner you may wish to discuss your feelings with them. If these feelings seem an important block to you, and you'd like to find a way to work with them, you may want to find a group to work with and share your experiences. Or you may want to find a mindfulness or meditation teacher, or a therapist who works with mindfulness, or offers you space and reflection for your feelings. The point is that there is nothing wrong with you or with your mindfulness if distressing feelings start to bubble up; this simply may be an indication that there are things you could address, and perhaps obtaining the help of others will be really useful to you at this time in your life.

Sometimes of course we focus our attention on certain things, or do certain things,

to avoid certain feelings, thoughts or memories. Again, this is very understandable, and sometimes helpful. For example, Karen, a young doctor, tried not to think about the death of a close friend when she was at work as she didn't want to be tearful in front of her patients. Sonia did not want to think about her unhappy childhood experiences in class when she was teaching. The ability to control attention and emotions is of course very helpful. The point is though, do we give ourselves the opportunity to create space and time to explore these things and themes and heal them, or are we always on the run from them? If you are very busy you may skip lunch, but if you keep avoiding eating your body will become weak. As they say, there is a time and place for everything. However, depressed people are notorious for never creating space, or finding it very difficult create space, to actually deal with the things that are hurting them inside.

If you are very depressed you may find these exercises hard because our positive systems are toned right down, but do have a go and give it some time. You may find the exercises easier as your mood shifts.

Overview

Mindfulness is a way of learning to use our attention and train our minds. What I have written here are some basic ideas. If these appeal to you then do seek out trained practitioners who can take you further on your journey of exploring mindfulness, teaching the traditions and opening up new ideas for you. There is much more to mindfulness than we have space to explore here.

KEY POINTS

- Our minds are often easily pulled and controlled by our emotions, key worries or moods.
- We can learn to become more aware of this and exert more control.
- A key skill is that of mindfulness which is learning to pay attention in a particular non-judgemental way. Recent research has shown this can be very helpful to people.
- Mindfulness can also be used to direct attention in a particular way, on specific activity.
- Mindfulness can be used to bring you a new interest in the world and appreciation of aspects of it.
- Directing our attention so that we learn to focus on the half-full rather than the half-empty glass, and learn to focus on what we can appreciate and enjoy in ourselves and others, can be helpful to our minds.

EXERCISES

Throughout this book we will be exploring various exercises. The more effort you can put into these exercises the better, of course. But some exercises suit some people better than others, so do find what suits you. On the other hand, don't give up on things too easily if you find the exercises difficult, because they might still be very useful to you. Indeed, the very fact that they are difficult may suggest a need for practice. Be honest with yourself. Here are some exercises in regard to mindfulness.

Exercise 1. Putting time aside to practise

You may listen to some of the CDs mentioned in Appendix 3. Or just practise your soothing breathing relaxation. Or seek out a group in your area to practise with.

Exercise 2. Bringing mindfulness into your everyday life

Whether you are waiting for a bus, having lunch or a bath, talking to your friends over coffee, practise being fully in the moment; if your mind wanders on to different topics, fears or concerns then gently bring it back. When talking to people, listen to what they are saying, rather than getting caught up in thoughts about whether they are interested in you.

Exercise 3. Sometimes just sit

Practise the ability to sit or just be with your thoughts and feelings and simply observe. Notice that you will have easy and hard days for this.

Exercise 4. The journey journal

Keep notes in your journey journal to reflect on how your practice is unfolding.

Switching our minds to kindness and compassion

This chapter explores some ways in which we can direct our thinking and attention to activate a soothing part of our brain. We're going to be looking at developing *kindness for ourselves and for others*. Both these can really help our minds become more settled and cope better with life difficulties. However, some depressed people are actually resistant or frightened of the idea of being kind to themselves, even when this can help with depression. If this idea of self-kindness seems strange or threatening to you, just stay with it for a while and later we will explore your *fears* of becoming kind, understanding and compassionate to yourself. But it is always just a step at a time.

In this chapter we are going to use our *imagination*. Some of you might think, 'Oh, I am not very good at imagining things, I have no imagination.' Well, don't give up on the idea yet, let's have a go and see how far we can get. In fact, you don't have to be good at imagining things; it's the act of trying that is important. The key is trying to direct your attention and create things in your mind that are good for your brain.

What imagery isn't

It is important to recognize that when we 'imagine things' we usually don't see detailed pictures in our minds. Generally, images are fleeting and we get fragments and glimpses of things. For example, if I ask you to imagine your favourite meal, or the house you might like to live in, or what you will be doing tomorrow, you probably will not get a clear picture in your mind; more like fleeting impressions and feelings. When we talk about imagery we are really trying to create 'a sense of' as opposed to a 'clear picture of'. It is about how we direct our attention, the focus of our minds. For all of the exercises below it's really the effort to create things in your mind, in a certain way, that matters rather than the results, or having clear pictures in your mind.

Mindful imagery

When we do these exercises we do them mindfully (see Chapter 7), aware that our attention will wander. You might be able to focus for a few seconds and then your mind wanders off to various things you have done, think you should do, or want to do

and so on. It does not matter if your mind wanders a hundred times, gently bring your attention back on to the task. The act of noticing and redirecting your attention is the important bit. If you find thoughts like ‘I can’t do this’, ‘I am not doing this right, I cannot feel anything’, notice these thoughts, and then gently and with kindness bring your mind back to what you’re trying to do. You will also notice that some days you will find it easier than others. In all these exercises there is no forcing or pushing oneself to do things. We simply put time aside to do the exercise, without judgement of whether it goes well or badly, because there is no well or badly (unless you make that judgement) – rather there is just ‘the doing’. Practice on a regular basis helps, of course, as it does for any skill we want to learn, be it playing golf, the piano, or painting – practice will help us improve.

Safe place imagery

The first imagery exercise we’ll do is about creating a place in our minds that we feel comfortable in. Let’s deliberately practise creating in our minds places that we find soothing, calming and where we want to be. To begin with, it is useful to start by sitting or lying down comfortably and going through your soothing breathing rhythm and a short relaxation exercise (see pages 123–5). If you don’t like the breathing exercise then sit quietly for a few moments. Then allow your mind to focus on *and create a place* that gives you the *feeling of safeness, calm and contentment*. The place may be a beautiful wood where the leaves of the trees dance gently in the breeze. Powerful shafts of light caress the ground with brightness. Imagine a wind gently on your face and a sense of the light dancing in front of you. Hear the rustle of the trees; imagine a smell of woodiness or sweetness in the air. Or your place may be a beautiful beach with a crystal blue sea stretching to the horizon where it meets the blue sky. Underfoot is soft, white fine sand that is silky to the touch. You can hear the gentle hushing of the waves on the sand. Imagine the sun on your face, sense the light dancing in diamond sparks on the water, imagine the soft sand under your feet as your toes dig into it and feel a light breeze gently touch your face. Or your safe place may be by a log fire and you can hear the crackle of the logs and the smell of wood smoke. These are examples of possible pleasant places that will bring a sense of pleasure to you, which is good – but the key focus is on feelings of *safeness* for you. They are only suggestions, and your safe place might be different.

When you bring your safe place to mind, allow your body to relax. Think about your facial expression; allow yourself to have a soft smile of pleasure at being here. It helps your attention if you practise focusing on each of your senses; what you can imagine seeing, feeling, hearing and any other sensory aspect.

It is also useful to imagine that as this is your own unique safe place, *the place itself feels joy in you being here*. Allow yourself to feel how your safe place has pleasure in your being here. Explore your feelings when you imagine this place is happy with you here.

When you become stressed or upset you can practise your soothing breathing rhythm for a few minutes and then imagine yourself in this place in your mind and allowing yourself to settle down, to give you some chill-out time. Keep in mind that we are using our imagery not to escape or avoid, but to help us practise bringing soothing to our minds. Keep in mind too that these are all what we call *behavioral*

experiments for you to try out and see what happens inside you. You get your own evidence for what is helpful to you, and build on that.

Compassion-focused imagery

Compassionate colour

Sometimes depressed people like to start off with imagining a *compassionate colour*. Usually these colours are pastel rather than dark. Engage in your soothing breathing rhythm and imagine a colour that you associate with compassion, or a colour that conveys some sense of warmth and kindness. Spend a few moments on that. Imagine this colour surrounding you. Then imagine this entering through your heart area and slowly through your body. As this happens, focus on this colour as having wisdom, strength and warmth/kindness, with a key quality of kindness. It would help if you can create a facial expression of kindness as you do this exercise.

One patient noted when he used compassion to help him face up to difficult decisions, the colour he associated with it became stronger. He was good at experimenting and seeing what worked for him; listening to his own intuitive wisdom. He began to think about his compassionate colours as helping him with different things.

Compassion qualities

Compassion is ‘being sensitive to distress with a desire and commitment to try to relieve it’. It is also an openness to the desires to see self and others *flourish*, and taking joy in that flourishing. Compassion and warmth are not just distress-focused – but a commitment for creating ‘contented joyfulness’ too. We can see compassion in lots of different ways, for example as simple and basic kindness, openness and generosity. We can add to these the idea that compassion is also related to *wisdom* (it can’t be unwise), *strength* (it is not weak and indeed often helps us develop courage), *warmth* (linked to the feelings of kindness) and non-judgemental attitudes. In the next chapter we will look at these qualities and skills in more detail.

The flow of compassion

Compassion-focused exercises and imagery are designed to try and create feelings of openness, kindness, warmth and gentleness in you. You are trying to stimulate a particular kind of brain system through your imagery. We can do this in a number of ways, such as using our memory and also our imagination.

Compassion-focused exercises can be orientated in three main ways:

- **Compassion flowing out from you to others.** In these exercises we focus on the feelings when we fill our minds with kind thoughts and wishes for other people.
- **Compassion flowing into you from others.** In these exercises we focus our minds on opening to the kindness of others. This is to open the mind and stimulate areas of our brain that are responsive to the kindness of other people.
- **Compassion for yourself.** This is linked to developing feelings, thoughts and experiences that

are focused on kindness to yourself. Life is often very difficult and learning how to generate self-compassion can be very helpful during these times and particularly to help us with our emotions.¹ The key is practising, developing and focusing your compassionate mind.

Now we are going to explore experiences for each of these three aspects. In all these exercises below it is your intentions and efforts that really matter. You may need to practise your feelings before they come naturally. So we can learn how to become compassionate because we try to practise thinking and acting compassionately, whereas the feelings may be harder to generate.

Becoming the compassionate self

The first set of exercises is focused on you practising generating feelings of compassion within yourself. Here we are going to work on your inner kindness and how to focus it, build on it, learn how to direct it and practise it. In a way we are going to use exercises that good actors use to create states of mind in themselves. For example, if actors want to convey anger or anxiety or sorrow, they try to create these feelings in themselves. Indeed when they ‘get into role’ it can actually change their bodies and physiology. If you get into an anger or anxiety role, your heart rate may go up. Imagining ourselves in a role, or as having certain feelings and thoughts, changes our physiology. We can use this well-known fact to create compassionate healing patterns in our bodies.

First, find a place where you can be alone and quiet. Now, gently, with your soothing rhythm breathing, if you can, imagine that *you are* a wise and compassionate person. Think about all the *ideal qualities* you would love to have as such a person. Imagine that you have them. It does not matter if you have these qualities or not in reality because we are simply imagining them. Research has shown that just imagining doing certain things changes our brains – and might actually make us better at that thing. Imagine that you have those qualities right now, in this moment. Imagine having great wisdom and understanding. Spend time imagining what that feels like.

Imagine having strength and fortitude. Spend time imagining what that feels like. Next imagine having great warmth and kindness and never being judgemental and again spend time imagining what that feels like. Think about what other qualities you’d like to have in your compassionate self. Imagine that you have them. Imagine your inner sense of calmness in your compassionate self that is based on wisdom. Try imagining each quality, noticing how that feels. Adopt a kind and gentle facial expression and spend time exploring that. Assume a body posture that feels compassionate to you, and spend some time exploring that too. You can also bring to mind ‘you at your best’, recalling a time you have felt calm, kind and wise. Breathe your soothing rhythm and focus on these memories and qualities.

Imagine the sound of your voice, your tone, pace and rhythm when you speak from this compassionate self. Imagine the emotion and feelings that are in you and are expressed in what and how you speak. You might imagine yourself as younger or older than you are now. Imagine yourself dressed in a certain way. I don’t know why, but for me I imagine having longer hair – it’s somehow associated with my image of a compassionate self. Maybe I am being kind to the fact that I am going bald!

Each day, put some time aside to ‘play with’ this role of being a ‘calm compassionate self’. Sometimes depressed people tell me that they’re like this already because they are kind to others. Indeed that might be so, but they can also be a bit submissive and do things they don’t really want to do because they want to be polite or they want to see themselves as a nice person and worthy of being loved (people pleasers). And that is perfectly understandable. However, the compassionate self we are thinking about here is not worried about what other people think. We have to distinguish true compassion and kindness from submissiveness.

Compassion under the duvet

Many meditation guides will advise you to spend time on your practice, perhaps sitting for 10 or 20 minutes a day. Tibetan monks may spend hours each day on their meditations. When we are depressed, that’s a bit tough! So let’s begin with what I call ‘compassion under the duvet’. When you wake up in the morning, or before you go to sleep, spend a moment or so with your soothing rhythm breathing, wearing a kindly expression and making a commitment to try as best you can, without judgement, to become a compassionate person. Focus on your kind facial expression. Imagine that you are a compassionate person and run through the exercise above.

Any time you have, such as waiting for a bus, or sitting on a train, or in a waiting room, or lying in the bath or walking – concentrate on your breathing and focus your attention on being a compassionate person inside yourself. These are times when our mind is often just idling along thinking all kinds of things, so why not use this time more productively to practise your exercises? You may find that if you practise *every day*, even if it’s only for a minute or two, the sense of compassion will actually stay with you more and more and you will want to practise more. Little and often can be very helpful.

Using your compassionate self

Different people find that they prefer to do things in a different order to that which is given here. Try for yourself and see what works for you. Perhaps focusing on compassion for others or developing your compassionate image (see below) is best for you as a starting place.

Wanting to be free of depression

When you feel you have the basic idea of imagining yourself as a compassionate being, and can notice but don’t engage (in fact smile at) all those thoughts that whisper in your mind, ‘No you’re not; you can’t do this; it’s not going to work you know,’ you can focus on a few key statements such as:

- May I be well.
- May I be happy.
- May I be free from suffering.

Focus on the *desires* in the words and your kindly facial expression. Feelings may come slowly with practice.

If you feel this is a bit overwhelming, pull back to focusing on just being a compassionate person; focus on your breathing, your facial expression and the tone of your voice. If you feel uncomfortable – say you feel you do not deserve compassion or for some other reason – then stay with the exercise for as long as you are able. You are slowly desensitizing yourself to fears and concerns about being kind to yourself. Try not to engage with arguments for or against in your mind – just do the exercise as best you can. If you feel very little, do not worry as the practice itself can be helpful – simply give some time to the exercise. Again, go at your own pace and explore how these ideas work for you. If this is still tough for you then you might want to start your practice with compassion for others (see below). If this is still difficult then there are other exercises throughout this book that you might get on with. The point is to try not to force anything – just be as mindful and open to possibilities as you can. It's like sleeping – we can't force ourselves to go to sleep, and if we keep checking 'Am I nearly asleep now?' it doesn't help. We can only create the conditions where sleep may occur.

Developing self-compassion for the difficult parts of ourselves

We are now going to use this compassionate self and focus it on others and on ourselves. When you feel you have practised becoming *the compassionate self* a few times, and are beginning to get the hang of it, you can use this exercise to help you cope with difficult feelings or setbacks in your life. For example, imagine that you are angry but are also fighting with yourself about it. Sit comfortably for a moment and create your compassionate self. Remember to adopt suitable facial expressions. If you have been engaged in your soothing breathing, just have a sense of your body calming. Now imagine your angry self; see it a few metres in front of you. Look at the angry expression and note the feelings inside this angry part of you – the frustration or sense of injustice – feelings that are not very pleasant. Now feel compassion for the angry part of you that you can see in front of you. You are not trying to change anything, because you realize that anger is part of our human brain that can be powerful and unpleasant. To the best of your ability, send compassion to that anger you see in front of you. It can have as much compassion as it needs. Notice what happens if you just sit compassionately with your anger.

If you find your mind wandering, refocus it on your powerful compassionate qualities. If you feel you are getting pulled into the anger and starting to feel angry again, then break off, pull back and re focus on your breathing and becoming the compassionate self. See your compassionate self as the wiser, older, more rooted part of yourself – *you at your best*. When you feel back in that role then re-engage. Your sense of yourself should also stay in the compassionate position, so pull back and refocus if that slips. If you feel yourself become critical of yourself, then again pull back and refocus on being the compassionate self.

Notice how if you hold your compassionate position, somehow that can feel quite powerful because it comes from a position of wisdom, fortitude and strength. Explore that sense of powerfulness from this position. I chose anger as the emotion to focus on here because anger and frustration are often emotions depressed people struggle with. Another emotion you might wish to work with might be anxiety.

When you feel ready you can engage with ‘the depressed self’. Once again see this (depressed) self in front of you, and in your wisdom recognize our brains have been designed to allow depression, and that is not our fault. Life can be very hard and painful. The depressed self is only one of many selves and brain patterns. The most important thing is to practise having compassionate kindness towards this self rather than anger, contempt or fear. And this is *not* self-pity or feeling sorry for yourself, because compassion asks you to develop wisdom, strength and courage as well as warmth and kindness.

When you first focus on the depressed self you might feel pulled into the depressed self, and tearful. Pull back, and refocus on the compassionate self so that compassion grows in you – feel yourself expanding and becoming stronger based on wisdom and understanding. This may take time.

People’s experiences with this can be very different. One woman felt tearful and cried, but felt this connected her with important feelings. She felt better because she was able to end her sitting with a compassionate focus. Another woman started out okay, but then felt overwhelmed and could not hold the compassionate self position. She needed more practice. Another person became agitated and had to work slowly on the compassionate self. The key thing is not to be overwhelmed but to work at your own pace and explore what is helpful for you. Your goal is to become kind to yourself and understanding of your depression. In these exercises we are not trying to change the depressed self but take a compassionate stance towards it.

Happy self

Recall a time when you were happy. Looking through the eyes of your compassionate self, see yourself smiling, happy and feeling content. Let your compassionate self feel joy for the happy self. Notice what feelings come up when you focus on being ‘happy’ – strangely it might make you feel sad because happiness might seem a long way away! Or you might notice other resistances. If so, stay with these feelings as best you’re able and always pull back to just *being the compassionate self* if it feels overwhelming. The important practice here is creating in your mind the potential for happiness and self and support from the compassionate self. We can learn to imagine ourselves as ‘well’, ‘happy’ and free of suffering. You can extend to any other positive aspects of yourself that you wish.

Compassionate practice is not just with threat-based feelings but with positive ones too!

Compassion and kindness for others

In our next exercise we are going to imagine kindness flowing out. Some of you might find this an easier exercise than the one above, so might prefer to start here. There is now increasing evidence that if we practise trying to focus on compassion for others this stimulates key brain areas which are helpful in combating depression and anxiety.²

Recall a time when you felt very kind and caring towards someone (or if you prefer, an animal). Don’t choose a time when that person was very distressed, because then you are likely to focus on that distress. As in the experience of remembering somebody being kind to you, ensure that you have space to practise without distraction, sit comfortably and engage in your soothing rhythm breathing.

Remember to create a kindly facial expression with (say) a slight smile. Notice your feelings in your body and the sense of yourself that emerges from such memories.

Next, bring to mind a person or people whom you want to feel you can help to be free of suffering. This may be a partner, a friend or a child. The idea is to *practise filling your mind with compassion for another* – you can choose who the other will be. Proceed with the following steps.

- Imagine yourself expanding as if you are becoming more powerful and wise.
- Pay attention to your body as you remember your feelings of kindness and the compassionate self.
- Spend a few moments feeling this expansion and warmth in your body (but don't worry if these feelings do not seem to be there – it is the trying that is important). Note your real genuine desire for this other person to be free of suffering and to flourish.
- Spend one minute thinking about your voice tone and the kind of things you say or the kind of things you might do or want to do.
- Focus now on your real desire for the person to flourish and be free of suffering. See them in your mind as smiling back at you. Focus on three key ideas (and the feelings and desire within them):
 - May they be well.
 - May they be happy.
 - May they be free of suffering.
- Spend one minute (more if you can) thinking about your pleasure in being able to be kind.
- When you feel able, you may also focus on feelings of kindness in general, the feelings of warmth, the feelings of expansion, the voice tone, the wisdom in your voice and in your behavior. When you have finished the exercise you might want to make some notes about how this felt in your body.

If you want to take this practice further, you can gradually expand the circle of people to whom you send your compassion – to friends and acquaintances, then to strangers and even to people you don't like. They too have all found themselves here with a brain they did not choose and passions, desires and feelings they did not design, and are ignorant of the forces that operate within them. However, this is more advanced practice and if you are depressed you might want to start slowly and build up. The basis of the practice is to fill your mind with desires and feelings for all living things to be free from suffering and to flourish. If you can expand your practice time to, say, five and then ten minutes. Longer would be helpful, but any time you can give to practice is useful.

Being joyful in other people's flourishing

In this exercise we are going to focus on creating what is called *sympathetic joy*, which is joyfulness in the flourishing and well-being of others.

Find a place where you won't be distracted and can sit comfortably and engage in your soothing rhythm breathing. Do that for about one minute until you feel ready to engage in the imagery. Now try and remember a time when you were very pleased for someone else's success or happiness. Perhaps it's someone close to you in your family; seeing them do well made you very happy. Recall their facial expressions in your mind. Feel the joy and well-being in them. As you do this, focus on your own facial expressions and feel yourself expanding as you remember the joyfulness of that event.

Notice how this joyfulness feels in your body. Allow yourself to smile. Spend two or three minutes sitting with that memory. Then, when you're ready, let the image fade and maybe write some notes.

In the next stage you can focus on your feelings of joy for the successes or relief from suffering of others, eventually expanding this to all living things.

Compassion flowing in

Imagining your ideal compassionate image

We are going to change the flow a bit. So far we have focused on your internal feelings of the compassionate self and being compassionate to different parts of you. Then we directed this to others and tried to fill our minds with kindness and wisdom. In the next exercises we are going to practise exploring our feelings as a recipient of compassion, by imagining another mind – wiser, stronger and warmer than our own – wanting us to be free of suffering and to flourish. I call this 'imagining your ideal compassionate image'. Let's now focus specifically on the ideal compassionate image that brings compassion for you. You can work on this using the worksheet on page 174.

The usual way we experience compassion is, of course, through the kindness of others. This usually flows in and through relationships. We can practise stimulating our soothing system by imagining *relating* to 'compassionate others'. Just as we can imagine ideal meals or ideal sexual partners, that can stimulate our bodies and physiologies in specific ways (see page 28), so we can create inner images that can stimulate the soothing system. The idea here is to play with, create, discover, build and develop your compassionate imagery; experimenting with what works for you. In fact the idea of imagining a compassionate other, and practising and focusing our minds on that image, as a way to help ourselves develop emotionally and heal, is thousands of years old.³

Let's think about how we might create a compassionate image that we can relate to using *fantasy images*. When you think of compassion, what kinds of images come to mind? Close your eyes for a moment and allow the word *compassion* or *kindness* to sit gently in your mind. What colours are associated with it for you? What sounds and textures? There is no rush. Maybe a mixture of colours and sounds come to mind.

In the next step we are going to focus on creating a specific image that you can feel has great compassion for you – that is 'is sensitive to your suffering and has a deep wish to help you with it.' The image that might arise could be of a person, but some people prefer animals, or even a tree or a mountain. Remember you might only get a fleeting sense of something (see pages 145–146). What are the qualities that you see as central to compassion? Spend a moment and think about that. It might be kindness, patience, wisdom, and caring. The act of thinking about compassion and its qualities helps you start to focus your attention on it. When you have had some thoughts of your own you can consider giving your image four basic qualities. We met them earlier, but let's look at them in a bit more detail now. These qualities are:

- 1 **Wisdom.** Imagine that your compassionate image understands completely what it means to be a human being, to struggle, to suffer, to have rage, feel depressed, but

also to have desires, to feel joy. It understands the evolved creation of our human minds with all their complex feelings, lusts, desires, happy and distressing thoughts, that can conflict inside us. It knows these are part of being human. Some people like the idea that their compassionate image has been through similar things to themselves but is now older and wiser; it understands you perfectly because it has been there itself. The image has a wise mind because it knows from experience, but has reached the point of inner peacefulness. This sense that it will have had the same feelings, conflicts, fantasies and emotions as you can be important as a source of kinship, and points (and can inspire us) to the ability to move on and develop.

In Buddhism certain images of compassionate others (called Bodhisattvas) are indeed like this. They have been fully human and subject to the same passions and desires, mistakes, aggressions, depressions and regrets as all of us, but through their training, study and practice have gained insight and developed compassion that has emerged from personal struggle and suffering.

- 2 **Strength and fortitude.** Give your image the ability to endure and tolerate painful things, but also the strength to defend and protect you if necessary. Imagine it as strong and courageous. As we will see later, sometimes compassion requires us to have courage. Sometimes, too, it requires us to be able to tolerate and not act on our more destructive thoughts and feelings, or learn to be assertive, or acknowledge we need to face things that we are perhaps frightened of facing.
- 3 **Warmth and kindness.** Imagine your compassionate image has warmth and kindness that radiates from and around it. This key quality is specifically there for you because this is your own unique image that you are creating and building.
- 4 **A non-judgemental/non-condemnatory approach.** Our compassionate image is never condemning, judging or critical. This does not mean it doesn't have desires or preferences. *Indeed, its main desire is for your well-being and flourishing.* Nor does being non-judgemental mean it is happy to go along with whatever feeling or action you decide; but it won't condemn you for it but rather invite you to understand your feelings and thoughts and choose a compassionate path – which at times can mean learning to be assertive.

So these are our key qualities that we are going to build into our compassionate image. The idea here is to create an image that is *unique and special for you*. The image is yours and yours alone. Keep in mind that it is *your ideal* and in that sense suffers from no human failings but is *fully and completely compassionate every time* because it embodies these qualities exactly. Note that the idea of it being 'an ideal' is that it is ideal *to you* (it may not be ideal to anyone else). You give it every quality that is important *to you*, just as if you thought about your ideal house, meal or car you would give it everything that you wanted and wouldn't hold back. So it is with your ideal image; you imagine it to have every aspect of compassion that is important to you. Deborah Lee has referred to this aspect as your 'perfect nurturer' – somewhat parental-like and protective – and some people really like that idea. Others see compassion in different ways, say as a friend or mentor – so you can decide exactly what qualities it has. Again, these kinds of exercises are used by various therapists to help people.⁴

Some people like to use religious images, for example of Buddha or Christ. If these images are helpful then by all means use them, of course, but for *the exercises*

we are doing here, create a new one just for you, because it also represents a creation of your mind; it is your inner sense of compassion that you are learning to give a voice to. Sometimes religious images can have associations that are not helpful – such as the concern that Christ might disapprove of sin – whereas the compassionate image we are developing here is never judgemental or punitive in any way.

Find somewhere to sit comfortably where you will not be disturbed, and decide if you want to use a CD of chants or music, or have (say) a water fountain on, or a candle or some other sensory aspect in the room. Later you may not want these additions, but they can be helpful to start with to create the mood. I know some pieces of music help me, but the choice of music can be very personal. Thinking about listening to and finding music that helps you and stimulates feelings of kindness and gentleness can itself be interesting and helpful.

Sit with eyes looking down or closed, and engage in your soothing rhythm breathing. When you feel that your body is now into the rhythm of breathing, start to imagine your ideal of compassion. Bring a slight, gentle smile to your face and consider the following questions.

- If you could design for yourself your ideal compassionate ‘other’ (that may or may not be a human person) – what qualities would it have? What would it look like?
If you are struggling with this, try this exploration:
- If you could design the ideal compassionate other for a child, what qualities would it have – how would it change as the child grows into an adult and what would it be like when the child is an adult?”

On page 174 there is a worksheet you can use. If you want to do this exercise then go to the worksheet now, read through the instructions, then engage your soothing rhythm breathing for 30 seconds and see what (if any) image comes to you. The idea is to do it mindfully so that if your mind wanders off task, you just bring it back.

When you are doing this exercise, go into as much sensory detail as you can. For example, think about how old the image is (if it’s a human one), the gender, type of eyes. Can you see it smiling? Do you have a sense of the hair style and colour? Do you have a sense of its clothes and postures? Next, focus on the sounds, the tone of the voice. If it communicates with you, what would it sound like to you? If there are any other sensory qualities that you would like your compassionate image to have, bring them into your exercise. One person I worked with saw a tall and bushy tree. It had been there for a long time and she felt she could snuggle into its branches and feel protected.

Think about how you would like your image to relate to you. Some people would like the image to seem older and wiser and very protective. For example, the person who thought of the tree for her compassionate image focused on its protective aspects, feeling surrounded by its branches. Other people like the idea of imagining being cared for, or cared about. One person wanted their image to truly understand how painful and difficult certain aspects of her life had been and still were. Sometimes our image may be parent-like – it can have all the qualities of the parent we always wanted, completely loving, forgiving and admiring; taking pleasure in our being. It is interesting to imagine that your compassionate image has ‘pleasure in your being’. Notice those intrusive ‘Yes, but.’ thoughts when you do this. They are common and understandable but, in this exercise, bring your attention back on task.

Your image might be not so much parent-like but more mentor-like or friend-like. It might give you the feeling that you are a valued member of a team or part of a community. This can be useful to help you think about feelings of belonging, and the idea of being in some relationship to others pursuing similar goals. This is central in Buddhist practice – feeling on the same journey with all others, with some being ahead of you ready to help. Your compassionate image can help you feel that we are all part of the human race. Even if you are depressed, remember there are many millions of people who suffer depression. If you see yourself as inferior or bad in some way, or are filled with anger or worry, remember there are many millions of people who feel as you do because we all have the same kind of brain. It is so easy to feel isolated. When we feel depressed we can make an effort to open our hearts up to the fact that depression is sadly part of the human condition. Our depression puts us right at the heart of being human.

Relating to your image

You might also think about how you would like to relate to your image, how you would like to speak to it, the kinds of things you would want to communicate to it. Spend some time imagining talking to your image. After all, think how much time you spend imagining talking to other people, what you might like to say to them. Sometimes people can find it useful to talk out loud, explaining their feelings but, when you do this, imagine that you're not talking to thin air but to a very compassionate, understanding other.

Keep in mind that we are using imagery, and the only source of these qualities is your own mind, so we are tapping your own inner wisdom about the nature of compassion. Keep in mind that you are using this exercise to put you in contact with your competencies and strengths within yourself. It is a way of contacting your own inner compassionate side; no one else can imagine it or create it like you can. This is for you – only you. Remember also that the images we have in our minds are not complete pictures; they are fleeting, impressionistic glimmers and glimpses. Do not worry if nothing clear comes to mind; just be aware that you are practising stimulating different systems.

Meeting your image

In some traditions of meditation imagery, such as Buddhist practices, there are a number of imagery exercises such as imagining a clear blue sky, and the emergence of a landscape with trees. One then imagines the Buddha under the tree and compassionately linking to the Buddha; imagining the Buddha sending compassion from his heart to your heart. At the end of the exercise the Buddha dissolves back into the landscape and the landscape dissolves back into a clear blue sky. This is to symbolize the emergence and dissolving of all things.^{2,3}

A variation of this which can be helpful is to imagine meeting your image in your safe place (see pages 146–7). Occasionally people feel they don't want anyone else in their safe place, compassionate or otherwise. Others, however, like the idea of meeting their compassionate image in this way. For example, if your safe place is by the sea you could imagine your image coming along the beach to meet you, smiling

and being delighted to see you. Sometimes seeing the image moving towards you, or the face breaking into a smile, is helpful. Sometimes people like to imagine sitting next to their compassionate image and the image having a very concerned, thoughtful and understanding expression; or, if it is a nonhuman image, to have a sense of concern, kindness and wisdom emanating from the image to the self. These are things to experiment with and see what helps you.

Difficulties with an image?

If, over a period of time, you are struggling to create any sense of a visual image then it may be that sounds would be an easier focus for you. You might think about the sound of a compassionate voice: is it male or female, softly spoken or powerful? One person I worked with had an image of a Buddha dressed as an earth goddess. She never *saw* this image clearly but she just had a sense of nurturing and great warmth. She could focus on this image or sense when she was distressed.

Another thing you can try, if you are struggling to generate an image or sound or sense, is to look through magazines or on the Internet for pictures of compassionate faces or people, and then use them as a template to get started on your imagery. Research has shown that if people practise focusing on looking for suitable pictures they are gradually training their brain to pick up on these cues, and this can have an impact on their self-esteem.⁵

Some people are not so keen on creating their own ideal, rather than of there being someone who wants to be compassionate to them. One person I worked with noted that, 'I guess in a thousand years we may be able to build robots that look, feel and sound like humans and can be extremely compassionate. However, I am not sure that would work for me.' This person wanted to experience compassion but from someone who wanted to relate to him, rather than someone whom he had created. However, we built into the imagery that his compassionate image wanted to relate to him but needed to be 'tuned into'. We can't communicate by e-mail unless we first turn on the computer and set it up to receive messages. Imagery practice means beginning to open up to hear these messages from within us. The point is that we want to stimulate our minds in certain ways. Clearly, if you feel that because these images are not real they are not helpful, then this may not be the exercise for you – at least, not yet. As with all these exercises, you have to find what works best for you.

Some people (often those who have been abused or have had difficult childhoods) can find human images too threatening. Sometimes they prefer to have a compassionate image such as a horse, an eagle, a mountain or a tree. These are fine, provided they are imagined as having human-like minds. The only slight problem with them is that it can be difficult to imagine a gently smiling or concerned compassionate face. Imagining this kind of expression on the face of another individual can be helpful, because there are areas in our brain that pick up on those signals and respond to facial expressions.

The exact relationship you have to your image can vary. For example, as I have noted, some people like to imagine their image as almost parental and they obtain a sense of being cared about and nurtured in a parental way. Other people like to think of their image more as a guide or a guru that is not nurturing them like a parent but guiding them. Yet others like to imagine their image as a companion. A variation on this imagery work can be to imagine that there are many individuals who are trying

to bring compassion to our difficult feelings and relationships. It is hard, but imagine being part of such a community who are seeking compassion and healing. You imagine yourself linked into (a part of) the community of individuals who are seeking to bring kindness to the harshness of the flow of life.

Sometimes it can be very interesting to change the gender of our image. This is perhaps a more advanced approach that you might want to explore when you feel okay with earlier ideas. Keep in mind that you can have different images if you wish.

Some people like to imagine the kindness and warmth of the compassionate image being focused as a kind of energy. People who use this approach have developed a form of working with images that they call HeartMath.⁶ This group of researchers has been studying various ways we can train ourselves to improve a physiological process called heart rate variability, and reduce our unpleasant emotions, by imaging compassion flowing into our heart region. You can find out more through the HeartMath website.

Grounding

We can use our compassionate imagery to stimulate certain patterns in our brain. As we will see in later chapters, we then want to use these patterns to help us. Sometimes this is to help us think things through in a kind and supportive way, or help us to engage in things that we find difficult. For example, supposing you have a difficult phone call to make. You can engage in the soothing rhythm breathing, spend a few moments imagining your safe place or compassionate image and it offering support for you. Then, from that state of mind, make your phone call. It's not magic, but it might give you a little helping hand to create these states of mind before the phone call.

If you do find this kind of imagery helpful then it can be useful to *ground* your imagery. This means that you practise your imagery while at the same time holding maybe a smooth stone or crystal or some other object in your hand. Then you can carry this object in your pocket so that when you hold it, it links you to the image and the feelings that you have been practising. You might like to find or buy a smooth stone or object that feels soothing in the hand and hold it while doing your imagination exercise. We call this grounding. Ideally, use something that can be replaced if lost, especially if you often have holes in your pockets!

In various spiritual traditions, imagery and invocation exercises are associated with other sensory triggers and processes called *mudras* and *mantras*. Mudras are gestures, body postures and hand movements that are associated with particular processes. For example, if you practise your compassionate imagery sitting in a traditional meditative style, i.e. sitting cross-legged or (what is more comfortable for many people) sitting in a chair, then you may want to rest your hands in your lap with index finger and thumb touching. This gesture can be used when doing the compassion imagery so that by breathing and holding the index finger and thumb together you can recreate the feelings generated in the imagery session. For example, you might have been practising your compassionate image at home in the morning. You then set off to work and are waiting for a train. What you do is engage your soothing rhythm breathing, hold your fingers in the same way and bring to mind your compassionate image or create within yourself the sense of being a compassionate

self. Don't forget that relaxed posture, slight smile and facial expressions, of course. You can imagine radiating compassion to everyone around you on the station – those who are also caught up in the flow of life and the hustle and bustle even though they may not want to be there either. Which finger the thumb touches can have different meanings in Eastern traditions. You can look these up on the Internet and read all about them if you are interested. Have some fun!

Overview

In many ways these imagery exercises are doing what all authors and writers of fiction do – which is to create scenes and characters in our minds. The only difference here is that you are doing this mindfully and exploring the impact on you from a soothing, connecting, compassionate point of view. If you come across images that don't work for you, then drop them. If you know that your images change, for example with (say) your menstrual cycle or some other cycle, go with the flow, provided it seems to connect with your soothing system.

Ultimately some people may find that they are attracted into the more traditional spiritual traditions and want their images to be traditional. The point about all of this really is not to get lost in complexity but to recognize the spirit and the purpose of your work. It is to help you stimulate patterns of activity in your mind that give you access to and help to develop a compassionate mind and a soothing mind. This takes practice; it takes time to recognize and work with a mind that is like a grasshopper, but if you stick with it you may find it is useful to you; you may find that you do indeed train your mind for compassion.

Fear of compassion

Some people recognize that they are simply not used to this way of thinking and it seems odd to them, but they can understand its value and the importance of practice. However, other people can be much more resistant. For example, they may feel they do not deserve to be kind to themselves, they may see it as a weakness, or a self-indulgence or even selfishness. If these beliefs are strongly held they can get in the way of practice. One way around this is to simply note these beliefs as common, but to practise anyway. Think about it like physiotherapy. If you had a weak muscle in your leg, perhaps as a result of injury, you wouldn't tell yourself you don't deserve to have a stronger muscle. Let's build these qualities, and then if you decide you don't want to use them, that's up to you.

For some people kindness begins to touch them in a deep way and can make them sad and even tearful. This is because it touches an inner wisdom, a 'knowing' – which is that many of us wish to be cared for, cared about and feel connected to others, and depression is such an isolating experience that there is a yearning inside us for reconnection. Some people are unsure about kindness because their parents could be kind one day but horrible the next. For them feelings of kindness and horribleness are somehow mixed up together. As they begin to feel kindness, the feelings of horribleness come back as well. If you feel like this, keep your focus on the feelings of kindness, notice other feelings creeping in, smile gently and bring the

attention back to exactly what it is *you want* to focus on. Only go with things you feel comfortable with.

Another major block to compassion can be anger. Depressed people can struggle with anger or even admitting they have anger (see Chapter 20). Others may have thoughts that it's not kindness they want to develop, but to find a way to fight back, to stand up for themselves or even get their own back on people who have hurt them! For people who feel like this, doing compassion exercises can actually make them feel a bit ashamed of their anger because they feel if they are compassionate they shouldn't feel angry. *This is a misunderstanding of compassion.* As we'll see in our chapters on anger, being able to be honest, and to acknowledge and express assertiveness are actually skills, but denying our anger or rage, sulking or telling ourselves we are wrong to feel it, or blindly acting it out – is not compassionate. Recognizing how painful rage is, is compassionate. Coming to terms with the fact that angry rumination is harmful to us is compassionate; learning how to work with anger is compassionate.

So there are many and various reasons why people can be wary of compassion and we will address these concerns as we go.

Overview and compassion practice

As in all things, practice will help you. To give you a plan and direction, try filling in the practice forms at the end of this chapter. These are really to focus you and give you an opportunity to reflect on your practice. Spend time with them if you can so that by the end of each week you can look back on what you've written on your practice imagery sheet.

As we go through this book we will be looking at your thoughts and behaviors. However, we will be doing this compassionately and you will often find that I suggest you create a gentle and kind position in your mind as you come to look at your thoughts and behaviors.

KEY POINTS

We have gone through some useful compassion-focusing exercises, derived from ancient wisdoms and practices and modern research, which focus on:

- compassion flowing out from you to others
- compassion flowing into you from others
- compassion for yourself.

Keep in mind these should be thought of as behavioral experiments, to see what happens if you put time and effort into practising. Each of these exercises may help stimulate part of your mind and brain that will help with bringing balance to your feelings and moods. Work through each one even if some are more difficult than others.

EXERCISES

Exercise 1: Building your compassionate image

This exercise is to help you build up a compassionate image for you to work with, and develop key areas of your mind. You can have more than one image if you wish, and they may well change over time. Whatever image comes to mind, or you choose to work with, note that it is your creation and therefore your own personal ideal – what you would really like from feeling cared for and cared about. In this practice it is important that you give your image certain qualities, including wisdom, strength, warmth, and a non-judgemental attitude. For each box below think of these qualities and imagine what they would look, sound

or feel like.

TABLE 8.1 BUILDING YOUR COMPASSIONATE IMAGE: WORKSHEET

How would you like your ideal compassionate image to look – visual qualities?

How would you like your ideal compassionate image to sound (e.g. voice tone)?

What other sensory qualities can you give to it?

How would you like your ideal compassionate image to relate to you?

How would you like to relate to your ideal compassionate image?

If possible, begin by focusing on your breathing, finding your calming rhythm and making a half smile. Then let images emerge in the mind as best you can – do not try too hard. If nothing comes to mind, or your mind wanders, gently bring it back to the breathing and practise compassionate acceptance. Here are some questions that might help you build an image:

- Would you want your caring/nurturing image to feel/look/seem old or young; male or female, or non-human – an animal, sea or light?
- What colours and sounds are associated with the qualities of wisdom, strength, warmth and non-judgement?

Indeed, if you only have a sense of a compassionate colour surrounding you that feels warm and caring, that's a good start. Remember, your colour and image has compassion for you.

TABLE 8.2 COMPASSIONATE PRACTICE DIARY

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Compassionate self (directed to self and/or others)							
Compassionate image							

In each box note the time and for how long you practised, what you found helpful and any other useful or interesting reflections.

Exercise 2: Experiments to try out

- See which you find easier: creating compassion by imagining being a compassionate self, and/or creating an ideal image that has compassion for you.
- What do you feel if you alter the gender of your compassionate image? This exercise is not helpful to everyone, so only practice what you feel is helpful.

These exercises can also be used as meditation practice, where you put time aside in a quiet space, but

also wherever you can focus your mind, e.g., in a break at work or on the bus.

Changing unhelpful thoughts and feelings: Balance and compassion

In the last few chapters we noted that, when we become depressed and feel low and tired, our thoughts tend to take us downward. They rarely encourage us or offer uplifts when we most need them. If anything, our thoughts are rather bullying and critical. In this chapter, we are going to explore ways of breaking out of this downward spiral. Look at the fourth column of the ‘Thought monitoring and creating helpful alternatives’ form in Appendix 1. We are going to learn about how to use this – how to create and refocus on helpful thoughts that are more likely to stimulate soothing rather than threat emotions in us. In the last part of the chapter I will explore with you how to make your own thought forms to suit your needs.

Before we get started, a word of warning. Depressed people are constantly being told that they are too negative and to look on the bright side and focus on positives. Of course, this is very unhelpful because depressed people know this perfectly well for themselves! Moreover, they can get a bit annoyed and resistant. As one of my patients said to me ‘I am fed up with being told I am too negative and to be more positive. The problem is I don’t have a positive thought in my head and if I did I wouldn’t be here.’ It’s a fair point. Everything that we outline below is an invitation to explore and try things out, become your own therapist, learning how to generate thoughts and behaviors that are genuinely helpful to you. It is absolutely not an instruction to ‘Look on the bright side’, ‘Give up your faulty thinking’ or other such unhelpful ideas. It is rather a journey into experimenting with new ideas and to discover helpful things.

Refocusing

Rational minds to the rescue

Our moods or fears colour and direct our thinking, so we have to help our thinking to stand back from them.¹ To help control the spiral downwards into depression, we need to stand back and encourage our *fair and rational* minds to do more work. As we noted in Chapter 3, high stress anxiety and anger can push this rational part of us to one side. Under stress, we automatically look at the negatives, so try to refocus those thoughts onto helpful ones.

One way of doing this is to be more rational, balanced and fair about them, so let’s look at the functions and qualities of the rational mind, since we want to recruit it to help ourselves.

- The rational mind likes to look at the evidence. It is like a scientist or detective and treats ideas and thoughts as theories that can be proved incorrect. The rational mind does not settle for simple answers; like Sherlock Holmes, it observes carefully and wants to know as much as possible before coming to a decision.
- The rational mind likes to have several alternatives to choose from. It does not like to have too few choices, because it tends to assume that there is always more than one way of seeing things.
- The rational mind likes to test things and run experiments.
- The rational mind does not like being overly influenced by emotional appeal or hasty conclusions.
- The rational mind knows that knowledge develops slowly. Things become more complex as we know more, and this is a source of fascination and deepening understanding.
- The rational mind knows that sometimes we learn most from trial and error – that, in fact, we often learn more from our errors than we do from our successes.
- The rational mind will attempt (if given the chance) to weigh up the advantages and disadvantages of a particular view or course of action.
- The rational mind likes to take a long-term view of things and recognizes that we often get to where we are going step by step. It realizes that it is our long-term interests that are important, regardless of short-term setbacks or benefits.

So the ‘rational and fair approach’ is a side of ourselves that we need to cultivate. We do this by deliberately trying to focus on this part of ourselves and asking ourselves, ‘What would my fair and rational mind (part of me) say about this?’

However, cognitive therapists point out that focusing on evidence and rationality alone is not always helpful and indeed can be positively unhelpful. Imagine that you are on the high-wire or climbing a steep rock face. You could look down and focus on the thought that if you slip you’ll die. That’s absolutely correct – no doubt about it – but it’s not the best or most helpful thought to focus on. It’s better if you look ahead, focus on one step at a time – and keep going. We only use our rational thoughts *if they are going to be helpful*.

In fact our rational minds work best at combating depression when they are focused and in the service of *compassion and kindness*; and cultivate our *compassionate mind*. Thus, we need to develop a *compassionate and friendly rationality*, not a cold and impersonal one. In the last chapter we developed various exercises to help us engage our thoughts and feelings with compassion. We are now going to use compassion focusing to help us with our depressing thoughts and behaviors.

The compassionate mind

In the last chapter we considered compassion based on wisdom, strength, warmth and non-judging or condemning. Our compassionate minds are empathic, kind and understanding. Can we treat ourselves like this so that when we generate alternative thoughts (with our rational minds) we hear them in wise, kind, gentle and helpful tones?

When we get depressed, there are not so many of these positive caring signals. We become more self-critical and generally negative. When times are hard we *do not* take an understanding, warm and kind approach with thoughts like, ‘Well, this has been hard for me and I am bound to feel sad and disappointed about it.’ Instead, we are more likely to become angry or feel hopeless, rather than understanding and supportive. It is understandable, because that is how the brain works – so we have to

make an effort to bring our soothing and gentle system back on line in our brain. To heal ourselves, there are things we can learn to cultivate a compassionate mind. The compassionate mind, like the rational mind, has certain qualities:

- empathy and sympathy for those who are in pain and hurting
- concern with growth and helping people reach their potential
- concern with supporting, healing and listening to what we and others need
- listening and enquiring about problems in a kind and friendly way
- quick to forgive and never condemning because it understands how hard being a human being is, with our difficult minds and brains that evolution has given us
- not attacking but seeking to bring healing, repair and reunion
- recognizing that life can be painful and that we are all imperfect beings
- not treating ourselves or others simply as objects with a market value – we are points of consciousness travelling through time (see Chapter 7)
- filling our minds with warmth
- helping us to develop courage to face difficulties in life – things we are frightened to confront but which might block our lives and abilities to grow and flourish.

We can learn to train our thoughts to be warm and friendly and cultivate the qualities of the compassionate mind. For some of us, especially those who have not received much in the way of warmth and kindness when young, this can be a most difficult but helpful step.

Compassionate mind training: the key elements

The components of compassion can be broken down into basic *attributes and qualities* and the *skills* of compassion. You may feel there are a lot of aspects here, but don't worry if you only get a sense of what we're talking about – that's fine. If you think that *the main quality of compassion is kindness*, and that is all you can recall – no worries – just stick with that.

Attributes and qualities

Looking at compassion in a slightly more technical way, we can see that it is made up of different aspects of our minds.

- **The first attribute and quality of compassion involves making a decision to try to be compassionate.** In other words, we are to be motivated to (want to) have a go at becoming more compassionate, to see this as desirable. We recognize that the compassionate self (see pages 149–53) is a self worth feeding and working to develop.
- **Second, we make an effort to train our minds to become sensitive to our feelings and thoughts.** We also need to become sensitive to our genuine needs. It's difficult to be self-compassionate if we are completely insensitive to our pain, upset, wants or needs, so we learn to notice our thoughts and feelings as they arise (see Chapter 7).
- **Third, compassion requires us to be emotionally open to our own suffering and that of others.** This means that we are emotionally touched, moved and sympathetic to suffering. Sympathy is an emotional reaction to our own and other people's emotions and states – it is that immediate wince if we see someone fall heavily or cut themselves. Sympathy can also operate when we are moved and take joy from the flourishing and well-being of others.
- **Fourth, we can only be open to feelings if we can tolerate them.** We have a variety of feelings, sometimes sad, angry or anxious and sometimes joyful. However, sometimes we are

critical of our feelings, or try to run away from them, hide from or suppress them. But when we are compassionate we can learn to be open, tolerant and accepting of our feelings. A key aspect of compassion is learning how to tolerate and come to terms with, become familiar with our feelings, and less frightened of them. This doesn't mean, of course, that we don't wish to change our feelings – for things or for other people or even ourselves. Indeed, we may well do, but we are unlikely to change through criticism, running away or suppressing our feelings; rather we have to face them openly and kindly.

- **The fifth aspect is called empathy, and this is about how we come to understand and think about our feelings and our thoughts.** We become open-hearted, curious, explorative, wanting to know why we feel what we feel or why we think what we think – so that things can make sense to us. When we have empathy for others we make an effort to think about things from their point of view, to understand that they may think and feel differently from us. This requires some work. For example, if somebody hurts you but you realize that they were under enormous stress, so you forgive them and don't take it personally, you are showing kind empathy.
- **Sixth is the important attribute of giving up and not engaging in condemning and judging.** The depressed mind can be filled with condemnation of self or others. Giving this up is linked to becoming mindful; we become more aware of thoughts and feelings but from an observing point of view. We don't judge them, nor suppress them or push them out of our minds, avoid or run away from them. Rather we learn to notice our feelings but not act on them.

Remember these abilities can be gained in small stages, step by step. All of them are engaged with a genuine desire to relieve suffering and increase our growth and flourishing. Although I try to develop my compassion, my beloved wife still tells me I am becoming a grumpy old man – so still much training required for me, I guess!

The skills of compassion

These involve learning to direct our *attention* in a compassionate and helpful way, learning to *think and reason* in a compassionate and helpful way and learning to *behave* in compassionate and helpful way – all of these with warmth, support and kindness. As we have said, is the glass half full or half empty? When something negative happens or you are unhappy with yourself, can you redirect your attention to something that is helpful? So the *attention* is very important. Mindfulness is about training our attention.

The next skill is compassionate *reasoning or thinking*. Can we train our minds to focus on reasoning and thinking about ourselves, our relationships and situations in a way that is compassionate and helpful? When we ruminate on our anxiety, disappointments, anger or aspects of depression this is only going to lock these feelings in. Can we practise deliberately choosing to refocus our reasoning helpfully – to really ask ourselves the question, 'What is a helpful way for me to think about this problem, situation or difficulty?' Imagine reasoning it through with a friend, or imagine having a dialogue with your compassionate image (see pages 159–166) and see what is helpful for you here, and what you need, to act on this. Do not become confused with the idea that compassionate thinking is simply 'being nice'. Thinking things through compassionately means being honest and at times thinking about difficult thoughts or painful, even aggressive, feelings and dilemmas.

The next skill is learning how to *behave compassionately*, in ways which you identify will be helpful to you and help you with your suffering and difficulties and move you forward in your life's journey. Sometimes compassionate behavior can mean being nice to yourself, recognizing if you need a holiday, if you need the

support of others, or just treating yourself kindly. Maybe you really need chill-out time in a nice bath, or to back off from things for a while. You recognize that you can't continue to deplete your resources: like a bank account you can't keep taking money out without putting some back – because then it gets empty! But compassionate behavior can also require courage to do things that may be blocking us. Sometimes it is about acting against the depression or anxiety and doing things even though we don't want to (see Chapter 12). It's compassionate because although taking what might seem an easier short-term path (e.g., avoid doing anything) might give us temporary relief, it doesn't take us anywhere in the long run.

Finally, a key skill to cultivate is generating feelings of warmth and kindness while doing all of the things we have mentioned. This is where many of us struggle. Some say they can feel kindness for others but cannot feel it for themselves. Don't worry too much about that, as it is common. We know that when we are depressed our feeling systems may not be working quite so well, so it's only natural if we struggle with the feeling. We might have to wait for that system to get going a bit. We can help it, though, by doing the exercises outlined in Chapters 7 and 8. We can train ourselves to practise compassionate attention, thinking and behavior, and allow the feelings to come with time.

Really the key issue for everything is learning to work out, and then focus on, what is helpful for you – but not in a selfish 'me-just-me' way, because you will find that is not helpful and other people will lose interest in you. Genuine compassionate helpfulness thinks about other people as well as ourselves. It is never submissive, however, and does not simply mean giving in to what other people want, leaving us feeling resentful or very needy for their approval. Learning to be assertive can actually be very compassionate. Compassion has to be wise, thoughtful, curious and open.

Compassionate attributes and compassionate skills are used to counteract the feelings, styles of thinking and behavior that arise in depression (a summary is given in Table 9.1).

Different states of mind

You might want to consider how, if your threat system is active so that we have 'threat mind', this will influence your feelings and motives, what you attend to, what you think about and how you think about it, and your behavior. The kinds of images and fantasies that pop into your head and your dreams may also have threat themes – because the threat system is active. When we are in 'threat mind' all these will be quite different to when we are trying to generate a compassionate mind (see figure 9.1). This is why making a real effort to create this mind can help us stand back from 'threat and depressed mind' and create different patterns in our mind and brain. With practice we might strengthen compassionate mind patterns – tough, but worth having a go.

TABLE 9.1 COMPASSIONATE ATTRIBUTES AND SKILLS

Compassionate attributes	Compassionate skills
Developing a motivation to be helpful and caring of self and others	Learning to deliberately focus our attention on things that are helpful and bring a balanced perspective, developing mindful attention and using our attention to bring to mind helpful compassionate images and/or a sense of self (Chapters 7 and 8)
Developing sensitivity to the feelings and needs of self and others	Learning to think and reason, use our rational mind, look at the evidence and bring a balanced perspective, writing down and reflecting on our styles of thinking and reasoning (Chapters 9, 10 and 11)
Developing sympathy, being moved and emotionally in tune with our feelings, distress and needs	Learning to plan and engage in behavior that acts to relieve distress, against the depression and moves us (and others) forward to our (or their) life goals – to flourish (Chapter 12)
Developing abilities to tolerate rather than avoid difficult feelings, memories or situations Developing our understanding of how our mind works, why we feel what we feel; how our thoughts are as they are Developing an accepting, non-condemning, and non-submissive orientation to ourselves and others	Learning to slow down and focus on feelings of warmth and kindness

Don't worry if this seems a bit of a handful and too many things to think about, or it seems too tough. As we go through the book you will see how we can use compassionate attributes and skills to help ourselves. Don't try and learn it all or remember it all. Even if you only have a very vague idea about kindness, that's fine.

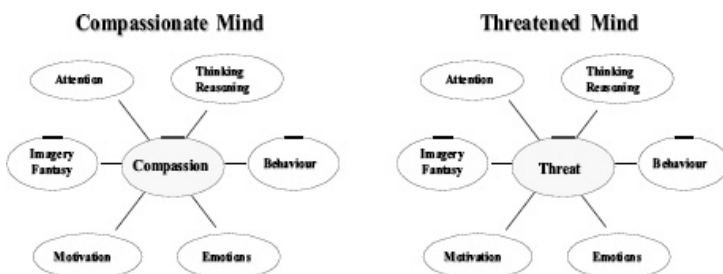


Figure 9.1 Comparing Compassionate Mind with Threatened Mind.

Questions that generate helpful alternatives

When we have depressing thoughts and feelings flooding in on us it can be helpful just to notice these and *push our pause button*. You could use your soothing

breathing rhythm, for example – just take a breath or two. Then, when standing slightly back from the thoughts we can learn how to generate alternatives and not be so caught in the narrow focus of threat, loss and depression. Thinking like this can be tough, but it's important to try. Below is a short selection of useful ideas, divided into three groups to get you started: some are based on rationality and logic, some are based on compassion; and some are based on a problem-solving approach to thinking about life's problems and tackling them in potentially helpful ways. Some will appeal to you more than others.

RATIONAL AND LOGICAL QUESTIONS

- What is the evidence that may support my belief and what is the evidence that may not support it?
- How would I typically see this if I were not depressed? To what degree therefore is this way of thinking reflecting my mood state rather than some 'truth'?
- What alternatives might there be to this view?
- What other explanations might there be for this event?
- What kind of thoughts would help me cope with this at the moment?
- How might I see this event in three or six months' time?
- What are the advantages and disadvantages of thinking about this difficulty in this way?
- What are the advantages and disadvantages of changing the way I think?
- If I overcame my depression, how might I look at this situation?
- What might I learn from changing the focus of my thoughts?

COMPASSIONATE QUESTIONS

- If I had a friend who felt like this, how would I help them see this differently?
- How would a kindly person, who was helping me with this, sound?
- How would I like someone who cared about me to help me see this differently?
- If my thoughts were sympathetic, warm and compassionate, what would they be and how would I feel?
- How would I like a caring person to be with me? How can I be like that to myself?
- If I put myself into compassionate self mode (see pages 149–155) what thoughts and ideas come to me?
- If I imagine my compassionate image (see pages 159–166), how might it help me see this differently; what kinds of things might the image say, and in what tone?

PROBLEM SOLVING

- How could I break this problem down into smaller chunks?
- Is there one bit of this problem I can tackle?
- How could I generate a step-by-step approach to this problem?
- Can I think of anyone who might help me?
- Can I ask them for their help and support?

Generating warmth

To generate warmth using thought records, start by writing down some of the

alternatives to your distressing thoughts that seem helpful to you (see Appendix 1 for examples). Suppose that you have the kind of thoughts noted above and you lie in bed a lot. You could say to yourself, ‘Come on, get out of bed, you lazy sod. You’ll only feel worse in there. For goodness’ sake make yourself a plan and stop feeling sorry for yourself’, and so on. Note that the tone is impatient and aggressive, even though you are trying to help yourself get up. Having thought or written out your alternative thoughts and got some plans to act against your depression, make sure they are not aggressive or bullying. Develop supportive thoughts, then read them through and express them in your mind *with as much warmth as you can*. If the words you have written down do not sound encouraging, but instead rather hectoring and harsh, try again to express them in less hostile terms. This may not be easy for you, but persevere: go over your alternative helpful thoughts a number of times, and each time you read them or rewrite them, *really feel* a certain warmth, understanding and encouragement coming through. If it helps, try going to your compassionate self first (see pages 149–53).

Looking for alternatives – balancing our thoughts

When we jump to conclusions, we usually don’t do much in the way of gathering evidence. We’d make very poor scientists or detectives. We often need to encourage ourselves to do this, and train ourselves to take the time to collect evidence. When we have a negative idea about ourselves, others, our future or the world, we need to ask, ‘Do I have enough evidence for this conclusion?’

Let’s look at a simple example. Anne thought she had ruined a dinner party by overcooking the meal, ruminated on what people must’ve thought of her and felt angry with herself and down. Suppose it is you who is struggling with this kind of event. How might we help you *not to dwell* on the overcooked meal, but instead to focus on what was good about the evening? (It is the old ‘glass half full or half empty’ issue, and you can choose where to focus your attention.) One way is first to go into the emotions (frustration and disappointment) be understanding and kind and ask, ‘What am I really thinking here?’ Take a moment to become more aware and clarify your thoughts by standing back a bit. Now take a thought, such as, ‘I’ve messed up the whole evening with my overcooked meal’.

- Recognize that (understandable) frustration and disappointment have taken hold of the way we think, and may be out of balance.
- Once we recognize that frustration and disappointment are running the show, we can learn to stand back and bring our rational and fair minds to our thoughts.
- We make a deliberate attempt to generate feelings of compassion and kindness towards the frustration by understanding it ‘as only natural’, but also gently take a wider, more balanced view because we don’t want to get stuck in those (understandable but unhelpful and depressing) feelings.
- Bringing a more balanced and wider view requires us to focus on four aspects:
 - our **attention** and what we focus on
 - the way we **think and reason**
 - how we focus on **helpful** and supportive behavior.
 - how we put **kind feelings** into efforts to help ourselves

Using Anne and her dinner party as an example, let’s spell this out by working on

the feelings and thoughts that ‘the whole evening was messed up.’ Look at Table 9.2.

So we have taken a simple event and looked at how to re-focus our attention, thinking, behavior and feelings. These are going to be the basis of all that follows in the rest of this book.

If Anne focuses on going through her alternatives, trying to *feel* support and kindness in the words, this will help. Again, you can try this for yourself. Read Anne’s alternatives through as if you’re trying to convince yourself of an argument. Judge it on its logic, evidence and accuracy. *Now read them through again, but this time focus on the kindness, support and warmth in the words* – the real understanding of the upset and fear. Stop reading and try it. Can you see how the combination of taking a rational and fair approach, and then putting kind feelings into it, can be helpful? That’s why we need our rational and compassionate minds to work in harmony with each other.

Conflicts and thinking about the minds of others

Conflicts with others are often a source of unhappiness, and some of our more extreme and black-and-white views emerge there. For example, Jane and Terry had an argument over money.

TABLE 9.2 USING OUR RATIONAL & COMPASSIONATE MIND

Rational mind	Compassionate/friendly mind (kind, warm tone)
Empathic understanding	
<i>My thinking is understandably clouded by my frustration, and it's difficult to be objective. Also I am anxious about what they might think of me and then how they will behave towards me.</i>	<i>It is understandable I feel frustrated because I put a lot of effort into the party and really wanted people to enjoy themselves and to feel good about me as the host in putting on a great party.</i>
<p>Here Anne shows that she recognizes the problems as frustration and anxiety clouding her feelings and thoughts. She is compassionate because she recognizes (is sensitive and sympathetic to) her frustration/disappointment as understandable and reminds herself why she feels like this, so she doesn't dismiss her feelings but accepts her disappointment with understanding – it is unhelpful to tell ourselves we should not feel what we do – when we clearly do.</p>	
Shifting attention	
<p><i>Where is the evidence that the whole evening was messed up?</i> <i>Our guests seemed happy.</i> <i>If I am unsure I could ask people.</i></p>	<p><i>It is understandable that my attention will be on the meal. Like the newspapers, humans tend to focus on the things that have gone wrong rather than the things that go right. Understandable, but not helpful – so to get more balance I need to refocus my attention on the good things and things I enjoyed about the evening. So I can close my eyes and bring to mind the memory of the party and now look around the room and remember people talking intently, laughing with and smiling at each other. Now I create that compassionate facial expression and see if I can feel any warmth for myself here – be in the pleasure of that shared enjoyment.</i></p>
<p>Here Anne is practising directing her attention in a different way and not letting her frustration dictate what she brings to mind. She is taking control and making choices about her attention and focus</p>	
Reasoning	
<p><i>Would you say the harsh things you are saying to yourself, to a friend or person you cared for?</i> <i>Do you think your friends will come again if asked? Yes, I am sure they would. So what does that mean? Well, I guess for them it was not so messed up.</i></p>	<p><i>With a friend I would help her to realize that it doesn't matter that much, we are all here having a good time, and we are very grateful for her efforts to put the party on so we can have a good time. Actually part of me would be relieved to know other people make errors too.</i></p>

Here Anne is learning to reason and think about the issue rationally and fairly and then with warmth and kindness, thinking of how she would talk about this if it happened to a friend. She is recognizing that her compassionate, caring side sees things and thinks about things in a different way to her angry, frustrated vulnerable side or part of her.

Behavior

Work out what went wrong and develop a plan to learn from the experience. All life is about learning from our mistakes and moving on. As Paul says in Chapter 22 of this book the secret to success and happiness is the ability to know how to fail – ah well.

It is understandable why I might feel I don't want to be bothered in the future. This is my frustration and vulnerability talking. It would help to have another go and practise building my confidence. If necessary ask people to come and help me.

Here Anne is thinking about compassionate behavior – behavior that will help her move forward, develop, learn from mistakes, grow and develop confidence. Compassionate behavior then is about kindness but is also about encouraging and being supportive in changing our behavior, taking on the challenges of change and not avoiding difficulties.

To generate compassionate feeling, Anne can now look through her alternative thoughts, engage in soothing rhythm breathing and focus on the words but imagine a compassionate image, or a compassionate voice speaking the words; in this part it is not so much convincing herself through evidence but focusing on the kindness, support and understanding in these alternatives that is key.

Because the argument got rather heated, Jane concluded that Terry no longer loved her. You can imagine the difference between having a heated argument, where you know it will end and you will go back to feeling that you care for each other, in contrast to losing contact with those feelings and memories. Sometimes, therefore, it really helps us to recognize when an argument is no more than an argument and is not an indicator of being unloved (despite our feelings in that moment). Table 9.3 shows how Jane might develop a more balanced perspective.

In this example we see that Jane tries to switch perspective and think about it from *Terry's point of view*. She tries to imagine what is actually in Terry's mind rather than just focus on her feelings and fears of being unlovable. This is using empathy: she has refocused her *attention from herself* to the mind of the other (Terry). If she then focuses on going through her alternatives trying to feel support and kindness in the words she has written down, this will help. The idea is not to 'excuse' Terry but to see how a shift of perspective can be helpful.

TABLE 9.3 REASONS WHY WE HAD THE ARGUMENT

Upsetting ideas	Compassionate alternatives
He doesn't care about me	<i>It is understandable to have those feelings when one has just had a difficult argument and given my background with my own family it is clear arguments like this are bound to stir things up in me (note how Jane is being sensitive and sympathetic to her distress here).</i>
	<i>He is worried about money too, and is prone to say hurtful things when he's worried and loses his temper, and if I'm honest so do I. Well, I think them even if I didn't say them. He is stressed out at the moment because of his job and it is difficult to be understanding and calm under that sort of stress. We wouldn't have gone at each other had we not been so stressed.</i>
	Here Jane is being sensitive and sympathetic to Terry. She brings to mind his coping style and that it is an issue with him, not about her – so her attention is not just on herself. She is also being honest about herself.
	<i>When things calm down it might be useful for us to talk about what happened and reflect on our experience, learn from it. It would also be useful for us to revisit the good things we like about each other and to remember that all of us need to keep things in perspective and how we might pull through this together.</i>
	Here Jane is thinking about what would be helpful behavior now. She recognizes that it would be helpful to learn to discuss and understand this difficulty in their relationship and then forgive and move on.

The idea of these examples is to give some thoughts and ideas that you can try for yourself. Note the importance of kindness in the alternatives. For example, read them through as if you're just trying to convince yourself of the reasonableness of the alternatives. Now read them through again but this time read them slowly and 'hear them in your mind' with as much kindness, support and warmth as you can. Look at them as wise ideas. Can you see the difference? This is why we need the rational mind to help us get a balanced perspective and the compassionate mind to generate the feelings for change and growth.

When Jane went through some alternative reasons for the hurtful things that had been said, she still felt unhappy about the conflicts in her relationship with Terry. However, she recognized that there were a number of factors related to the argument and not just the idea that she was not loved. When the heat had gone out of the situation, she decided to talk to Terry about this. At first, he said that he thought that she didn't really understand how he felt and how difficult things were for him – in other words, it was not that he did not love Jane but that he felt mis-understood by her. Although they then got into something of a competition over who was the less understanding, eventually they talked about the fact that the shortage of money was the common problem. They agreed that both were under stress because of that, and that they needed to join together against the common problem rather than venting their anger at each other. This would have been difficult to achieve if Jane had hung on to the idea that Terry's anger was evidence of his not loving her. In fact, both of them tended to interpret arguments as evidence of a lack of love.

Of course, it may well be that, when you are angry, the person you are arguing with is not your best-loved person *at that moment*; but this does not mean that you do

not love them, nor does it mean that they don't love you. And we all need to watch out for the terrible 'must': 'I must be loved all the time', or 'In a love relationship we must never be angry with each other'. Many people in good, caring relationships have times when they wonder why they got married at all and why they are still there! But in the back of their minds they know that these feelings and thoughts are coming from the moment, the power of the emotion, and in a few days' time they will feel different again.

Time to break up

Sometimes, however, the evidence points in the other direction – that there may not be much caring in a relationship. Karen had been going out with Tim for about 18 months. He tended to be demanding and rough sexually. At times he would come to her flat drunk, and he often broke their dates. Increasingly depressed, Karen made excuse after excuse for him. It was her *positive* ideas that were the problem not her negative ones (see Table 9.4).

TABLE 9.4 THINKING OF ALTERNATIVES	
Positive ideas	Alternatives
He'd change if we were married.	When I saw his last girlfriend she said that he was the same with her and that I was welcome to him. All accounts I have read suggest that, on the whole, people don't change that much after marriage.
This is typical of all men.	I know many other men who are not like this.
When he's down, he always likes to talk to me.	There is more to a relationship than just supporting people when they are down. I might be being used here.
He is often nice and takes me out sometimes.	Even Hitler was nice at times. It's really what I feel about it overall that counts.

Here Karen needed to focus primarily on the evidence that this is not such a loving relationship. Doing this was difficult for her, but when she began to look at alternatives to her idea that Tim did care for her, unfortunately the evidence was that he did not – or at least, not in the way that she wanted. 18 months was a reasonable time to get enough evidence!

Generating alternatives means that we get more than one point of view. Sometimes we don't want to think about the alternatives because they lead to painful decisions. In Karen's case, she had a deeper belief that if she gave up this relationship, she might not find another. It was this belief that had stopped her looking at alternative thoughts about whether Tim cared or not, and really focusing on the evidence that he did not. When she did look hard at the evidence, she realized that, on the whole, this was not a good or supportive relationship to be in. There was more pain than gain.

When she tried to use her compassionate mind by focusing on how she might talk to a friend, Karen came up with these ideas:

I know I'm worried about being on my own. But I can learn to face this possibility. I

might be more miserable if I stay in than if I get out. Even if I get out of this relationship, this doesn't mean that I'll give up trying to find a better one. I can think about the qualities I could bring to a relationship and not just focus on my bad points. I'm honest and very loyal. I try to consider other people's feelings. Of course, no one's perfect but I deserve better. In my heart, I know this. It has just seemed too frightening to end it. But then again, I have survived on my own before, and rather than hoping that a relationship with a man will make my life great, I can start to work on relationships with other people who can give me some pleasure and closeness. Ending this relationship doesn't make me unlovable.

Karen wrote this down and recorded these ideas on tape when she wasn't feeling too depressed. She was then able to read and listen to them whenever she felt down. She was encouraged to feel kind and compassionate when she offered herself these alternative ideas and words of advice (today I would stress this aspect much more). This helped her to stop sinking into depression and face up to getting out of the relationship. Once again, we see compassion is about the *courage* to be honest and to act.

One typical response at this stage might be, 'Well, okay, I can generate alternative views; but I don't really believe them. I'm just trying to fool myself.' If this is what you think, consider that this is typical of depression – depression always thinks it knows what's real and accurate. At this stage, the act of generating alternatives and avoiding concentrating on single ideas is the important first step. Then bringing in the feelings of caring and kindness can help even more. Even if it is difficult to generate kindness in your alternatives, don't worry because it's the practice and the effort that count. Sometimes people like to start from the caring position or to imagine their compassionate images, or become the compassionate self and think of the alternatives once they have those feelings a bit – try it and see which you like.

Conflicts and dilemmas

Writing things down can also help you to clarify conflicts and dilemmas. In this case you can write down two columns: advantages (pros or gains) and disadvantages (cons or losses) of making a change. Kevin was in two minds about moving house, so he wrote out the advantages/pros and disadvantages/cons (Table 9.5)

Advantages (pros)	Disadvantages (cons)
Nicer district	Further to travel to work
Bigger house with more space for the family	Unfamiliar; I like my present house
Bigger garden that I could enjoy and relax in	Might not have the time to maintain it
Good investment	More expensive

Kevin's next task was to weigh each pro and con. He did this with his family, with him and his wife putting arguments for and against. Through discussion, it became clear that it was the un-familiarity of a new house and district that was the biggest hurdle. Kevin realized that he did not like to leave the familiar. Once this was clarified in his mind, he was able to reconsider this view and accept that although it

might take him time to adjust to a new home, in the long term it would be a good decision to move.

Sometimes we can feel very blocked in changing our basic views of ourselves or changing our ways of doing things. There always seems to be a cost or fear. In therapy, Karen realized that, if things went wrong in relationships, she tended to blame herself. Although she readily acknowledged that giving up doing this would be helpful, she found it difficult to do. She wrote down the pros and cons of giving up self-blame to discover why (Table 9.6).

TABLE 9.6 PROS AND CONS OF GIVING UP SELF-BLAME		
Advantages		Disadvantages
I would feel better	but	I would become more angry with others I would become like my mother who always blamed others, and whom I disliked
I would take more risks	but	I would provoke others to be angry or reject me
I would not feel inferior	but	I might not see my faults, and might become arrogant

By writing these thoughts down, it became clear that, for Karen, there were a number of unrecognized disadvantages to changing – not least *the fear* of becoming the kind of person she did not like. Of course, no one would change if they saw that as the possible result. Karen needed to consider the evidence for the disadvantages that she had identified. What evidence was there that not taking the blame for everything would make her arrogant? Aren’t there lots of people who do not blame themselves but are also not arrogant? See the responsibility circle on page 285.

Fear of change

In therapy, people often see many disadvantages to changing. Of course, they don’t want to be depressed – but getting out of depression may appear to involve rather difficult things. We identify what these might be. What would change involve? What might be the fear in that? Not every advantage of change has a countering ‘but’ or problems associated with it; still, it is useful to think of such possibilities. We can continue to resist change if the perceived disadvantages and fears associated with change are not explored. Once we can see more clearly what is blocking us, we may be better placed to start (kindly but firmly) challenging some of those blocks.

Sometimes advantages and disadvantages are not seen. For example, someone who feels a need to be in an intimate relationship to be happy can become dependent and tend to stay in unsupportive relationships – as in Karen’s case. Someone who, by contrast, feels a need to be strong and independent might suffer the disadvantage of being unable to ask others for help. They may keep others at arm’s length and find it difficult to let other people become emotionally close.

You can do these written exercises on pros and cons many times, and can carry them out quite slowly, allowing time for self-reflection and/or discussion with others along the way.



KEY POINTS

- To help us shift depressed brain patterns it helps to have two types of focus: balanced thinking and a compassionate focus.
- Gaining balance requires us to generate alternatives and to think about an issue, belief, or problem from as many different angles as we can. This practice helps us to break out from the narrowed vision that depression can sometimes give us.
- Our compassionate mind is not irrational but focuses on wisdom with feelings of warmth, support and kindness.
- Important qualities of compassion include the desire and motivation to be compassionate, being sensitive and sympathetic, learning to tolerate painful feelings, being able to think about painful feelings in ourselves and in others so that we get a balanced and insightful perspective and understanding. Compassion can require that we develop courage. Compassion is not condemning or judgemental because it is based on the recognition that human minds and situations are complex, difficult and often harsh.
- Rational and compassionate skills involve us learning to pay attention to things that are helpful and trying to get a balanced approach by reasoning and thinking through things in as balanced and compassionate way as possible, orientating behavior towards helpful actions.
- Regaining balance can be helped by writing things down (see Chapter 11), considering the advantages and disadvantages of things, imagining oneself in the shoes of others.

EXERCISES

In these exercises we are going to combine some of the principles of mindfulness (Chapter 7) with using our rational and compassionate minds. The first exercise is learning to be mindful and accepting of our negative thoughts and feelings without worrying that we have to change them – this helps to take the pressure off ourselves.

Exercise 1

Write down your depression-linked thoughts about some situation, which will normally be something you feel threatened by or on which you are loss-focused. It usually helps if we start off with something that's not too major and gradually work up to more difficult things. Engage in your soothing breathing rhythm and allow your thoughts to be there as thoughts that have emerged in your mind. In this exercise you are not trying to change them but just be mindful and aware of them. The key here is learning that we can sit with them quietly, focusing on our breathing 'in and out', the rising and falling of the chest as we breathe, the point just inside the nose where the air comes in. In this moment we are simply breathing and noticing.

Exercise 2

In this exercise imagine your compassionate side (and this may be imagining yourself as a compassionate person or imagining your compassionate image) to be in a conversation with you. Imagine warmth, kindness and understanding for your depressing thoughts and feelings. Again we are not trying to change anything at this point; rather we are developing our compassion for our situation. Let your thoughts be there, with compassionate understanding for them. This can help you to stop fighting with yourself and condemning yourself for what you feel. Try to feel compassion for your situation and feelings – remember that you did not design your brain or choose to feel like this.

Exercise 3

Look at your thoughts and think about them with kindness but also from different points of view. Are there things that you can focus your attention on, that will be helpful to you? As a compassionate person, how would you like to talk to a friend in your situation? How would you like your compassionate image to talk to you and support you? Remember your compassionate side is wise and is not persuaded by negative feelings. It will help you to think about reasons to be more balanced in your thoughts. You could try writing this down, if that helps you.

These exercises are designed to begin the process of developing your rational balancing and compassion skills as guides on the road out of depression. All the time, remember you are the best judge of what works for you, so try out different things and don't be put off if something seems difficult as this may be exactly the thing you need to practise and to try out.

Styles of depressive thinking: How to develop helpful styles

This chapter looks in more detail at the kinds of ways our thoughts can become problematic for us when we get depressed and how to work with them in a compassionate way. Depression can often be linked to difficult life situations: conflicts and problems in relationships, or at work, or with finances, or physical health, or feeling stuck in places we don't want to be. Coping with these can be hard, but it can become even harder because as we become depressed, the way we think changes. Threat and loss-focused thoughts, interpretations and memories become much easier to bring to mind and dwell on. There is a shift to what is called a *threat and loss (negative thinking) bias*, and then we are on a downward spiral.¹ A typical spiral is outlined in Figure 10.1.

As our thinking follows a downward spiral, we start to look for evidence that confirms or fits our negative beliefs and feelings. We may start to remember other failures, and the feelings begin to spread out like a dark tide rolling in to cover the sands of our positive abilities. Such thoughts tend to lock in the depression, deepen it and make it more difficult to recover from (see page 101). They drive a vicious circle of feeling, thinking and behavior – and this gives us one route into disrupting the depressing spirals.

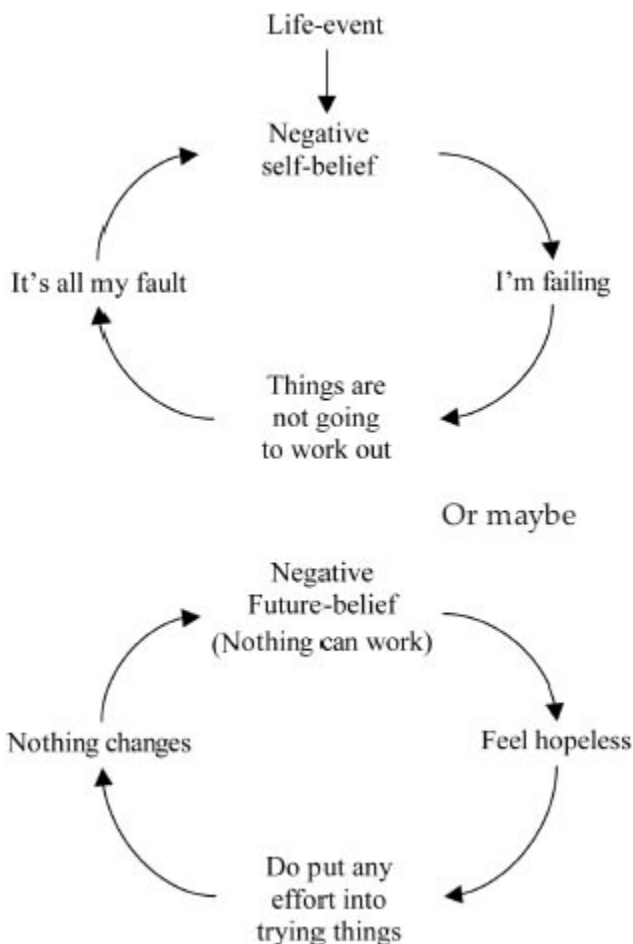


Figure 10.1. A typical downward spiral.

Certain *styles* of depressive thinking are fairly common. Professor Beck, who started cognitive therapy, noted about six or seven types of negative (or as I prefer to call them 'threat-focused') thinking biases.² We will explore some of them here. To work on our biases in a more balanced way, we have to (1) recognize them and (2) make an effort to bring our rational and compassionate minds to the problem. It is important to recognize that humans are often not that logical or rational – we can be, but we have to work at it. In fact a lot of research has shown that many of our ways of thinking about ourselves, other people, different groups, and our hopes for the future can become very biased and inaccurate – even at the best of times!² So working for balance takes effort and training of our minds. Below we go through some typical biases that tend to appear with depression. We'll start with jumping to conclusions because this is absolutely typical of the threat-focused and 'better safe than sorry' mind.

Jumping to conclusions

If we feel vulnerable to abandonment, or have the basic belief, 'I can never be happy without a close relationship,' it is natural that, at times, we may jump to the conclusion that others are about to leave us. This will often impel us to cling on to these relationships, unable to face up to our fear of being abandoned.

The part of our mind that focuses us on threats will tell us that we could not possibly cope with being alone. We might worry about how we think we could cope with everyday life, or we might worry about being overwhelmed by grief, feelings of loss and emptiness. Sometimes these feelings go back to childhood. If you have a fear of rejection or of losing a relationship, one way of helping might be to write down that fear and see if you can think of ways of coping with a break-up – if it occurs. Of course, the break-up may be painful: you can't protect yourself from life's painful things, but you can work out how to be supportive and compassionate to yourself in this time of difficulty. It's hard but it can help us to actually shift our attention and think about how one *could* cope. For example, be understanding and kind to your distress: it is only natural to feel upset. We might consider how we could elicit help from friends, or remind ourselves that, before we had a relationship with this person, we had coped on our own; or that many people suffer the break-up of relationships and survive. There might even be advantages in learning to live alone for a while.

Putting thoughts into the minds of others

Another form of jumping to conclusions is called 'mind reading' or sometimes projection. We make assumptions about their thoughts and feelings. For example, we may automatically assume that people do not like us because they do not give sufficient cues of approval or liking us. In 'mind reading' we believe that we can intuitively know what others think.

The key point here is mindfully examining your thoughts rather than automatically assuming that your thoughts about what other people are feeling and thinking are accurate. Research has shown that some people struggle here. For example, parents may believe the annoying behaviors of their children are to wind them up; they take it personally. Or that disobedient children are showing that they don't care about or respect the parent; again they take it personally. But they are reading intentions into their children that simply are not there. Young children are not thinking about 'the mind of the parent' at all. They are not thinking about how to 'wind the parent up' or cause them emotional upset – they are simply behaving in these ways to try to get what they want. It's about them – the child – not the parent.

So the way we attribute intentions and feelings to other people's behavior is important. When we get depressed we often think other people's withholding, avoiding or ignoring behaviors are directed at us. Some men think that if their wives do not want to sleep with them when they want to it's because they don't love them enough – in reality there may be differences in sex drive, or timing or desire. Women may feel that if men don't talk about feelings it's because they don't love them. In reality the man may have difficulties in talking about feelings in general. When people disappoint us it's important to think that maybe it's not really about 'us' or

‘me’ it’s about ‘them’. We have to find ways to be compassionately understanding and explore (take time to think about) the ‘minds of others’ in more detail.

Predicting the future

We often need to be able to predict the future, at least to a degree. We need to have some idea about what threats, opportunities and blocks lie ahead to know whether to put effort into things or not. How much energy and effort our brains devote to securing goals depends a great deal on whether we have an optimistic or a pessimistic view of the future. It may be highly disadvantageous to put in a lot of effort when the chances of success appear slim. The problem is that, as we become depressed, the brain veers too much to the conclusion that nothing will work, and continuously signals: ‘times are hard’. Depression says, ‘You can put a lot of effort into this but not get much in return. Close down and wait for better times’ (see Chapter 3). Getting out of depression may involve patience and a preparedness to think that the brain is being overly pessimistic about the future.

Emotional tolerance versus avoidance

Our brains have evolved over many millions of years to be able to have very strong emotions. One of our greatest difficulties is learning how to tolerate and come to terms with strong emotion. We can certainly look to how our thoughts may be making them stronger than they need be, but it’s also important to learn to tolerate the natural and normal power of our emotions; to recognize that there’s nothing wrong with us in having strong emotions. Rather it’s the way we deal with them, either by acting on them impulsively or by trying to get rid of them, avoid them, suppress them, or deny them that causes the difficulties.

A colleague told me a sad story he read in a local newspaper. A woman who was looking for her local Alcoholics Anonymous meeting got lost and couldn’t find the way there. She became upset, frustrated and anxious, so she sat in her car and drank a bottle of wine. She was picked up by the police well over the limit. She had simply not been able to tolerate the upset without wanting to turn off those intense feelings.

Another type of avoidance is the person who feels angry with a parent (say), but is frightened to acknowledge it or work through it. When anger arises she distracts herself or binge eats. Or a person may be frightened of (say) homosexual thoughts and feelings and so drinks to avoid them; or might drink to avoid feelings of loneliness or shame. We can run from all kinds of emotions. Our emotions can also stop us from doing things. Consider a socially anxious person who would love to go to university but the anxiety dictates their actions and they don’t go. Think about how often fears and worries stop you from doing things you really want to do. Sometimes we think about this in terms of confidence, but often it’s about our ability to tolerate emotions and act against that emotion. Most addictions, forms of self-harm, anxiety disorders, reckless and impulsive behavior and some depressions are linked to problems in tolerating emotions.

Given the problems we have with strong emotions and our ‘old brains’, distress tolerance is key to well-being. Compassion can be very helpful in how we learn to

work with and tolerate strong emotions. Here are some ideas to have a go at.

Step 1: seeing the point of having a go

- Make a commitment to learn to tolerate your emotions as something you want to learn to do.
- Recognize the value of doing this; see how it will strengthen you.
- Consider the value in giving up the short-term benefit of trying to avoid your emotions (e.g., by avoiding them, drinking or binge eating) in favour of the longer-term benefits of tolerance.

Step 2: what to do next

When you have agreed your motivation then these are some things to try:

- Develop an attitude of mindfulness, with two types of focus:
 - Sometimes distractions help – focus on something outside of yourself in the ‘here and now’ such as the colour of someone’s clothes, or floor patterns. When I was anxious about giving talks I would try and see a face in the audience that looked friendly and focus on that person, or look just above people’s heads.
 - The second form of focusing is to pay attention to how your emotions feel in your body; become curious about them, notice how they come with certain types of thinking and urgencies. You become the observer.
- Put your emotions into words as they’re happening: ‘I am beginning to feel frustrated and this is because . . . It is affecting my body by . . . and I am noting a certain urgency . . . There is nothing wrong with me for feeling emotions like this because . . .’ Our brains can give us strong emotions. Research is showing that putting ‘emotions into words’ helps to slow us down and stimulates certain areas of our brain that can help us.
- As you notice emotions arising, focus on your soothing breathing rhythm.
- Make a commitment not to act on your emotions immediately. Pull back and observe them as best you are able.
- Remind yourself there is nothing wrong with you for feeling strong emotion (look out for self-criticism).
- If you find yourself thinking, ‘This is unbearable, intolerable, impossible’ and so on, acknowledge these thoughts as notions and judgements that reflect a certain fear in you. However, remember you have made a commitment to try to hold the line – at least for a while.
- Keep in mind that these emotions will settle down in time: ‘this too will pass’.
- Perhaps you might remember previous occasions when this has happened, so stay with your breathing and focus on ‘This will pass. By tolerating this I am becoming stronger and stronger.’
- If you can give yourself some time where you tolerate your emotion, even if it’s only a few moments, you are beginning to learn how to do it.
- Be aware of any threat-focused thoughts such as ‘I will lose control,’ ‘this emotion will harm me’, ‘I’m a bad person for feeling this emotion.’ Think through alternatives: ‘I have had these emotions before and have not lost control or been harmed; these feelings are common throughout the world so it can’t be me who is bad. Even if I can only tolerate the emotion briefly it’s a start.’
- Learn to acknowledge, value and praise your courage.

Step 3: compassion focusing

- With your soothing breathing rhythm, create a compassionate facial expression.
- Imagine that you are a compassionate person who *can* tolerate strong emotion. See an image of yourself tolerating the emotions and being pleased afterwards.
- Bring to mind your compassionate image and imagine talking out your emotion to your image.
- Write a compassionate letter in your mind about your emotions or what you are feeling this

In these exercises you are practising buying time, being *with* your emotion, and tolerating it. These are just some ideas and you may find others once you have committed yourself to learning to tolerate strong emotion. It's not easy, but over time it will get easier for you. Regular practice of mindfulness and compassion work can actually help us become calmer inside. You may also have your own ways of working on this issue. For example although I am not religious myself, I know it can help some people. One woman thought about Jesus: 'If he can tolerate that, I can tolerate this'. She did not use this to shame herself about her emotion (there are no 'shoulds' and 'oughts' here), rather it helped her feel 'one with the suffering of Jesus' and was very helpful to her. A person who was trying to control her urges to eat when hungry thought about starving children in the world. If they can tolerate that, she could tolerate her urges. It's not unknown for actors to have severe nausea, even vomiting, on the first night of a play, but they work through it because they really want to act. The first step is really getting clear in your mind the advantage of learning toleration, of putting up with painful feelings.

Emotional reasoning

One of the reasons that we can have problems with emotion tolerance is because our emotions can be more powerful and long-lasting than they need to be. Strong feelings and emotions pull and push us into thinking in certain ways, and this can happen despite the fact that we know it is irrational. The problem is that, at times, we may not get our more rational and compassionate mind to help us. Given the strength of our emotions, we may take the view, 'I feel it, therefore it must be true.'

Feelings are very unreliable sources of truth. For example, at the times of the Crusades, many Europeans 'felt' that God wanted them to kill Muslims – and they did. Throughout the ages, humans have done some terrible things because their feelings dictated it. As a general rule, if you are depressed, don't trust your feelings – especially if they are highly critical and hostile to you. In Table 10.1 there are some typical 'I feel it therefore it must be true' ideas with some alternatives.

In their right place, feelings are enormously valuable, and indeed, they give meaning and vitality to life – we are not computers. But when we use feelings to do the work of our rational minds, we are liable to get into trouble. The strength of our feelings is not a good guide to reality or accuracy. See if you can come up with any other alternatives for the thoughts and ideas in Table 10.1.

TABLE 10.1 FEELINGS, NOT FACTS

Situation	I feel it, therefore it must be true	Alternative balancing ideas
Going to a party	I feel frightened, therefore this situation is dangerous and threatening	This is related to my shyness and confidence, not any actual danger — I can go a step at a time and be kind with my feelings.
Feeling anxious	I feel as if I will have a heart attack, therefore I will	This is understandable anxiety which can feel like this — but I have had these feelings many times before and it was anxiety not a heart attack.
Being accused of a minor fault	I feel guilty, therefore I am guilty and a bad person	It is understandable to be disappointed but there is so much more to me than that — feeling a bad person is maybe a reflection of my annoyance at being criticized. Learning to cope with criticism will strengthen me.
Losing my temper and shouting	I feel terrible when I get angry, therefore anger is terrible and I am bad and rejectable	Yep anger is not a nice feeling but it's very much part of human nature — I did not design these feelings — and I am trying to understand and work with my anger.
Wanting to cry	I feel that, if I start crying, the flood gates will open and I will never stop; therefore I must stop myself from crying	It is easy to feel overwhelmed especially if one is not used to crying and being in touch with one's pain — but crying does subside and I have shown myself to be effective in turning off my emotions if I really need to. Maybe a little at a time, and staying with my emotions might actually help me.
Feeling self-conscious when I cry	I feel ashamed when I cry, therefore crying is shameful and a sign of weakness	Crying is a very important human response built into our bodies. Crying is the display of our pain and is basic to our humanity. Other people have probably shamed me for crying so it is their shame I am feeling.
Making a mistake	I feel stupid, therefore I am stupid	Who hasn't felt that awkward when one does something a bit thoughtless careless and daft — but one cannot sum up a complex self like this. My annoyance is probably driving this feeling and my compassion can actually get stronger if I used it right at these moments.

'I must'

Over 2,500 years ago the Buddha said, 'Our cravings are the source of our unhappiness.' He also suggested that it is our attachment to things, our '*must haves*' and '*must bes*' and '*others must be as I want them to be*' feelings and beliefs that lead to suffering — not least because life is not like this. All things are transitory and it is coming to terms with that and living in 'this moment' that matters. Look out for feelings that indicate you are '*must-ing*' yourself. As we become depressed, and sometimes before, we can believe that we *must* do certain things or *must* live in a certain way or *must* have certain things, e.g., others' approval, or achieve certain

standards, e.g., weight loss.

By gaining control over our musts, ‘got to haves’ and cravings, we are gaining control over our emotional minds. Whatever your own particular ‘musts’, try to identify them and turn them into preferences. Recognize that reducing the strength of your cravings can set you free, or at least freer, and remember that there is often an irony in our ‘musts’. For example, at times we can be so needing of success and so fearful of failure that we may withdraw and not try at all. If you go to a party and feel that ‘everyone *must* like you,’ the chances are that you’ll be so anxious that you won’t enjoy it and even may not go. And if you do go, you may be so defensive that others won’t have a chance to get to know you.

Disbelieving and discounting the positive in personal efforts

If we have been threatened or experienced a major setback, we may need a lot of reassurance before trying again. This makes good evolutionary sense: it is adaptive to be wary and cautious. We even have a saying for it: ‘once bitten, twice shy.’

The problem is that in depression this same process can apply in an unhelpful way. If we have experienced a failure or setback, we may think we need to have a major success before we can re-assure ourselves that we are back on track. Small successes may not be enough to convince us. However, getting out of depression often depends on small steps, not giant leaps. Typical automatic thoughts that can undermine this step-by-step approach are:

- I used to do so much more when I was not depressed. Managing to do this one small thing today seems so insignificant.
- Other people could take things like this in their stride.
- Because it is such an effort for me, this proves that I am not making any headway.
- Anyone could do that.
- Small steps are all right for some people, but I want giant leaps and nothing else will do.

Remember what we have said about depression – your brain is working differently. Perhaps the levels of some of your brain chemicals have got a little too low. Perhaps you are exhausted. Therefore, you have to compare like with like. Other people may accomplish more – and so might you if you were not depressed – but you are. Given the way your brain is and the effort you have to make, you are really doing a lot if you achieve one small step. Think about it this way. If you had broken your leg and were learning to walk again, being able to go a few paces might be real progress. Depressed people often wish that they could show their injuries to others, but unfortunately that is not possible. But this does not mean that there is nothing physically different in your brain and body when you are depressed than when you are not.

If you can do things when you find them difficult to do, surely that is worth even more praise than being able to do them when they are easy to accomplish. We can learn to praise and appreciate our *efforts*, rather than the results.

A crucial thing to remember is that you are training and stimulating your brain. By focusing on small things that you can appreciate and give yourself praise for, you will stimulate important positive emotion areas of the brain. *Although understandable, it is not helpful to keep dismissing these opportunities to stimulate your brain in a positive way.* Try not to get caught up in debates with yourself about

whether you deserve it, whether you should do more and so on. Focus on it as ‘physiotherapy for your brain’; exercising and stimulating key systems in your brain over and over again as often as you can.

Disbelieving the positive from others

Another area where we disbelieve the positive is when others are approving of us. To quote Groucho Marx, ‘I don’t want to belong to any club that will accept me as a member.’ Even being accepted is turned into a negative. Here are some other examples:

- When Steve was paid a compliment at work by his boss, he thought, ‘He’s just saying that to get me to work harder. He’s not satisfied with me.’
- When Ella was asked how she had been feeling when she returned to work after being ill, she concluded, ‘They’re just asking what’s expected. They don’t really care, but I guess they’ll feel better if they ask.’
- When Peter passed a nice comment on how Maureen looked, she thought, ‘He’s just saying that to cheer me up. Maybe he wants sex’.
- Paul sent in a report at work, even though he knew there were one or two areas where it was weak. When he got approving feedback, he thought, ‘Deceived them again. They obviously didn’t read it very carefully. No one takes much notice of my work.’

Rather than allowing himself to keep on thinking so negatively, Paul was encouraged to ask his boss about his report, especially the shaky areas. He didn’t get the response he expected. His boss said, ‘Yes, we knew those areas were unclear in your report, but then the whole area is unclear. In any case, some of the other things you said gave us some new ideas on how to approach the project.’ So Paul got some evidence about the report rather than continuing to rely on his own feelings about it.

From an evolutionary point of view, the part of us that is on the look-out for deceptions can become overactive, and we become very sensitive to the possibility of being deceived. Moreover, fear of deception works both ways. On the one hand, we can think that others are deceiving us with their supportive words and on the other, we can think that, if we do get praise, we have deceived *them*. Because deceptions are really threats, when we become depressed we can become very sensitive to them. But again we can try and generate balanced alternatives to these ideas. For example:

Even if people are mildly deceptive, does this matter? What harm can they do? I don’t have to insist that people are always completely straight. And life being life, some people are more deceptive than others. But I can live with that. To be honest I can be deceptive too – it is part of being human.

As a rule of thumb, it can be useful to take people at face value unless experience proves otherwise.

All-or-nothing

All-or-nothing thinking (sometimes also called either/or, polarized or black-and-white thinking) is typical when we are threatened. If we might be under a threat we often need to weigh this up quickly. Animals often need to jump to conclusions (e.g., whether to run from a sound in the bushes), and it is easier to jump to conclusions if the choices are clear – all-or-nothing. So our threat system can go for ‘better assume

the worst' and 'better safe than sorry'. See if you can spot these in the list below.

- My efforts are either a success or they are an abject failure.
- I am/other people are either all good or all bad.
- There is right and there is wrong, and nothing in between.
- If I'm not perfect, I'm a failure.
- You're either a real man or you're a wimp.
- If you're not with us, you're against us.
- If it doesn't go exactly as I planned or hoped, it is a fiasco.
- If you don't always show me that you love me, you don't love me at all.

All-or-nothing thinking is common for two reasons. First, we feel threatened by *uncertainty*. Indeed, some people can feel very threatened by this. They have to know *for sure* what is right and how to act and they may try to create the certainty they need by all-or-nothing thinking. Sometimes we may think that people who 'know their own minds' and can be clear on key issues are strong, and we admire them and try to be like them, but watch out. Hitler knew his own mind and was a very good example of an all-or-nothing thinker. Some apparently strong people may actually be quite rigid. Indeed, I have found that some depressed people admire those they see as strong individuals, but when you really explore this with them, they discover that the people they are admiring and trying to be like are neither strong nor compassionate. They are rather shallow, rigid, all-or-nothing thinkers who are always ready to give their opinions. A lovely motto someone gave me once was 'indecision is the key to flexibility'.

There is nothing wrong with sitting on the fence for a while or seeing things as grey areas. Even though we may eventually have to come off the fence, at least we have given ourselves space to weigh up the evidence and let our rational minds do some work.

The other common reason why we go in for all-or-nothing thinking has to do with *frustration* and *disappointment* (see Chapter 21). How often have we thrown down our tools because we can't get something to go right? When you get frustrated you tend to take a more extreme view. It is emotions that drive this view, so balancing of all-or-nothing thinking and our tendency to make extreme judgements of good/bad or success/failure can be very important in recovering from depression. The state of depression itself can reduce our tolerance of frustration and push us into all-or-nothing thinking, so we have to be aware of this and be careful not to let it get the better of us.

All-or-nothing thinking can be unpleasant for other people too. Tim talked about his mother who was depressed and how she found frustration very difficult. 'Small things would set her off and then you would never know what mood she would be in.' Tim could identify this as black-and-white and rigid thinking. 'Things had to be just so and if they weren't she'd get angry, anxious or withdraw.' Tim understood that this related to various stresses in her life. Nonetheless, seeing this allowed Tim to reflect on himself and he decided he didn't want to be like that. When he felt frustration mounting in him he would begin his soothing rhythm breathing, consider if his thoughts and feelings were rather black-and-white and practise being compassionate and tolerant in that context.

Overgeneralization

If one thing goes wrong, we can think and feel that everything is going to go wrong – our emotions go on a rollercoaster. When we overgeneralize like this, we see one setback or defeat as a never-ending pattern of defeats. Nothing will work; it will always be this way.

- a student received a bad mark and had a heart-sink disappointment feeling and concluded, ‘I will never make it. My work is never good enough.’ (linked to anger, frustration and anxiety)
- a friend had told Sue that she would come to her party, but then she forgot the date. Sue thought, ‘This is typical of how people always treat me. No one ever cares.’ (linked to anger, frustration and anxiety)
- Dan broke up with his girlfriend and thought, ‘I will never be as happy again as I was with her. I will always be miserable without her.’ (linked to sadness)

So it’s important to be aware of the arising of feelings and meanings and the thoughts that tumble along with them.

In Table 10.2 we can explore some typical balanced and compassionate alternatives for working on our tendencies for overgeneralization. Notice that we always start with being understanding and kind for the distress we feel.

TABLE 10.2 ALTERNATIVES TO DEPRESSING THOUGHTS	
Depressing thought	Balanced and compassionate alternatives
Things will never work out for me	When I am upset it is typical for me to think like this – so I can be wise and kind to myself by recognizing it is my upset that is doing the thinking
	‘Never’ and ‘always’ are big words. I have thought like this before and things did work out – at least to a degree
	Let’s take some soothing rhythm breaths and slow myself down a bit and give myself some space to think
	Now what would I like a really kind and compassionate person to say to me right now (really spend a moment on this idea and go with that)
	Rather than just blanking out everything I could think that things might go okay
	Predicting the future is a chancy business. Maybe I can learn how to make things go better. I don’t have to load the dice against myself
	If a friend had a setback, I would not speak to them like this. Maybe I can learn to speak to myself as I might to a friend.

Egocentric thinking

In this situation, we have difficulty in believing that others have a different point of view from our own. The way we see things must be the way they see things – e.g., ‘I think I’m a failure, thus so must they.’ We discussed this on page 207, in the section ‘Putting thoughts into the minds of others’.

But there is another way we can be egocentric in our thinking. This is when we insist that others obey the same rules for living and have the same values as we do.

Janet was very keen on birthdays and always remembered them. But her husband Eddie did not think in these terms; he liked to give small presents as surprises, out of the blue. One year, he forgot to buy a present for Janet's birthday. She thought, 'He knows how important birthdays are to me. I would never have forgotten his, so how could he forget mine? If he loved me, he would not have forgotten.' But the fact was Eddie did not really know how important birthdays were to Janet because she had never told him. He was simply supposed to think the same way as Janet.

In therapy together with Janet, Eddie was surprised at how upset she had been and pointed out that he often brought her small surprise presents, which showed that he was thinking about her. He also mentioned to her – for the first time – that she rarely gave gifts except at birthdays, and to his way of thinking, this meant that she only thought about giving him something or surprising him once a year!

All of us have different life experiences and personalities, and our views and values differ, too. These differences can be a source of growth or conflict. It is because we are all different that there is such a rich and varied range of human beings. Unfortunately, at times we may downgrade people if they don't think or behave like us. On the book stands today, you will find many books that address the fact that men and women tend to think differently about relationships and want different things out of them. This need not be a problem if we are upfront about our needs and wants and negotiate openly with our partners. It becomes a problem when we are not clear with them about our wants or we try to force other people to think as we do.

Dwelling and ruminating

As we noted on pages 113–4, dwelling and ruminating on the threats and losses in our lives can be a source of maintaining your brain in a state of threat and stress. All the ways of thinking noted above can feed into 'dwelling and ruminating'. Some people also think that this is a way to solve problems and, if limited, thinking things through can of course be helpful. However, going over and over things that upset you or make you angry or anxious is not helpful. The steps are:

- Practice noticing your ruminations when they start up.
- Become mindful and notice the paths your thoughts tread – pull back to your observing kind and curious mode.
- Make a commitment to gently refocus your attention – maybe with an activity or bring to mind a helpful image or something that is more likely to stimulate positive feelings in your brain.

KEY POINTS

- The way we think about things can lead us further into depression rather than out of it.
- When we are depressed, our brains change in such a way that we become very sensitive to various kinds of harm, threats and losses. It is (or was) adaptive for the brain to go for an 'assume the worst' and 'better safe than sorry' type of thinking when under threat. In these situations, control over our feelings is given more to the threat system in our brain and less control is given to the rational, kind and compassionate systems (see Chapters 2 and 3).
- There are some typical types of thoughts that are encountered in depression. These include jumping to (negative) conclusions, emotional intolerance, 'I must', dismissing the positives, all-or-nothing thinking and overgeneralizing. We can try to work with these.
- One way to help is to recognize the typical styles of depressive thinking and open our hearts to generating compassionate balanced alternatives; to deliberately switch our attention, thinking and behaving away from the threat system into a more balanced and compassionate system.

EXERCISES

Exercise 1

Review the different types of thinking outlined in this chapter. Consider which ones seem to apply to you (see Appendix 2 for a quick overview of some typical types of threat-focused thinking).

- If you have written down your thoughts, consider which kind of depressive style each thought may be an example of – for instance, is it like jumping to conclusions, or emotional reasoning, or all-or-nothing thinking? You may find that one of the styles (e.g., all-or-nothing thinking) crops up in many different situations. That is certainly one of my styles when under stress.
- Use your rational/compassionate mind to generate alternatives; think of questions to put to yourself. Do you have enough evidence for your view? Is this a balanced view? Would you put it to a friend like this? If you are to be really kind now, what would you think? Are you trying to force a certainty when none exists? Are you disbelieving the positives? Are you frightened of believing in the more balanced and compassionate alternatives?
- Consider how you might help someone you like generate alternatives to, say, all-or-nothing thinking or jumping to conclusions. Practise being gentle with yourself rather than harsh and critical, and practise seeing things in grey rather than insisting on black and white.
- Work on emotional balance and feeling tolerance as noted above.
- Focus on what you can do rather than what you can't. Have the motto, 'The secret of success is the ability to fail.' (See Chapter 21 for further discussion of this motto.)
- Ask, 'How am I looking after myself? Do my thoughts help me care for myself?' Slowly build on your insights.

KEY POINT

Always have a go at spending a few moments on your breathing and then trying to shift to the compassionate self or bring to mind your compassionate image (see Chapter 8). Once in that frame (even if only slightly) it might be easier to generate and think about compassionate alternatives.

It can also help to be mindful of your thoughts – note them in your mind and stand back from them – view them from the balcony as it were – watch the mind shift to black-and-white thinking or over-generalizing. It can seem odd and difficult at first, but with practice it can be very interesting. There is no forcing or trying to make yourself change your mind – just be open to the possibility for change and see what happens.

Writing things down: How to do it and why it can be helpful

Learning *to write* about your thoughts and feelings, especially to begin with, can be helpful. Here are some of the reasons why.

- **Writing down is slowing down.** The first reason is that writing slows our thinking down and helps us to focus. It helps to stop those half-formed but emotionally powerful thoughts whizzing around out of control.
- **Attention.** Writing things down helps concentrate our attention and enables us to stand back a little. Seeing the words coming on to the page helps us to distance ourselves from the thoughts, as we have to focus on the process of writing.
- **Catching thoughts.** By slowing down and focusing we may discover all kinds of thoughts ‘lurking in the background’. One way of catching our thoughts, and inner meanings we put on things and feelings, is by being gently curious and asking ourselves some questions such as those I outlined on pages 107–8. Also, having felt something, you stop and say, ‘How can I account for what I feel? What am I thinking?’ This can help to pinpoint and identify our thoughts. The more you slow your thinking down, especially by writing, the more likely you are to ‘catch’ the key thoughts and meanings that are associated with what you are feeling.
- **Clarity.** Writing down is an excellent means of gaining clarity. When you have written your thoughts down, you have a record of them in front of you; something you can look over calmly to see how your thoughts may be understandable given your depression and life difficulties, but not helpful to you – and if you dwell on them they will make you feel worse.
- **Gaining a perspective.** Seeing your thoughts written out in front of you may well help you see that your depression is pushing you to be overly negative (loss- and threat-focused) and losing perspective. This is much more difficult to see if you just work with your thoughts in your head, because it is hard to gain the distance that is achieved by writing them down.

Thought forms

Thought forms offer ways of helping us to organize our thoughts and to distinguish between situations that trigger our feelings and moods, the kinds of thoughts and feelings that pour through our minds (often in a chaotic way), and then how we can re-focus our attention on generating helpful alternatives. Thought forms are just useful guides to help our practice and develop our minds: see Appendix 1 for some ideas.

My advice here is: keep it simple. Use whatever kind of form suits you, rather than struggling with something that you find too complex – provided it does the job, of course. The most basic thought-alternative form is simply a page divided into two columns. You write your unhelpful, threat-focused thoughts in the left-hand column,

and helpful, compassionate alternatives in the right-hand column. These depressive thoughts might be triggered by an event, or might come on as your mood dips. The key point is *catching* what these thoughts are and offering a balanced and compassionate alternative to them.

Table 11.1 shows an example of a completed form.

TABLE 11.1 COMPLETED THOUGHTS FORM	
Depressing thoughts	Balanced alternative thoughts
Here I am just lying in bed again	I have to admit I am not feeling too good right now
Can't see the point of getting up	Even though it will be a struggle, if I can try to gently encourage myself to get up and move around a bit this often helps
Things are bound to go wrong	If I can achieve a couple of things I'll feel better
Nothing is worth doing anyway – I won't enjoy it	Sure, I don't enjoy things much because I am depressed – the trick is doing things to overcome depression. I know I can enjoy things when I am not depressed. So I will do my best to work against my depressed brain state
Degree of belief: 70%	Degree of belief: 40%

Rate your belief

You will see that at the bottom of each column in this example there is a figure for 'degree of belief'– that is, *how much* do you believe what you have written down? Some people find that if they rate how much they believe something this can be helpful for seeing that beliefs are not black and white, all-or-nothing. As time passes and you start to feel better you'll be able to look back and see how the strength of your beliefs has changed with your recovery. Other people don't find this particularly helpful, because they feel it is artificial in some way. Once again, find what works for you.

Make up your own column headings

You can make up your own column headings for different tasks. For example, sometimes it can be useful to write down in two columns (1) the reason why you believe and then (2) in the other column the reasons to change that view, or consider the advantages and disadvantages of a particular belief. You might prefer to label the two columns 'what my threat- or loss-focused and/or self-attacking mind says' and 'what my rational and compassionate mind says'. For all these variations you can use the two-column format and simply change the headings to suit.

Adding more columns

In the thought forms given in Appendix 1 you will see other columns. In addition to the two noted above, we also have a column for writing down any critical *events* that might have triggered your distressing thoughts and a column for describing

distressing *feelings*. This helps to give you a more complete picture; it will help your progress if you can be clear on what kinds of things tend to trigger your change of mood, arouse negative thoughts and feelings, or what those emotions and feelings actually are.

Rate change

It can sometimes be useful to rate the change in the strength of your beliefs and in your emotions after you have been through the exercise. For that, we might add a third column to the simple two-column form. Table 11.2 shows the same examples we used above, with the third column added on.

TABLE 11.2 CHANGING THOUGHTS		
Depressing thoughts	Helpful thoughts that operate against the depression	How I feel now compared to before
Here I am just lying in bed again	I have to admit I am not feeling too good right now. Even though it will be a struggle, if I can gently encourage myself to get and move around a bit this often helps . . . (etc.)	Yes, I can see that this might be helpful and a way forward
Can't see the point of getting up	Even though it will be a struggle, if I can try to gently encourage myself to get up and move around a bit this often helps.	
Things are bound to go wrong	If I can achieve a couple of things I'll feel better	
Nothing is worth doing anyway – I won't enjoy it	Sure, I don't enjoy things much because I am depressed – the trick is doing things to overcome depression. I know I can enjoy things when I am not depressed. So I will do my best to work against my depressed brain state	I feel maybe 5% less depressed by compassionately refocusing my thoughts

Try as best you can, with an encouraging, supportive (not bullying) tone in your mind to carry out your plan to get up and out of bed, move about and do something active, no matter how small. You might rate how you feel having done this, compared to how you were feeling before you started. Note the difference. You could even compare how you feel now with how you might feel if you had not done anything at all but stayed in bed. The point here is that the more you yourself see the value in these kinds of exercises the more you are likely to have a go.

Adapting the basic idea to suit yourself

Once you have got the basic idea of the importance of writing things down and slowing your thinking down, you are prepared to start working on your thoughts, feelings, and moods. However, the exact framework you choose to do this should be something you decide for yourself: it's important that you are happy with the form you use.

Different forms will be useful for working on different things. I have started us off here with a fairly basic thought-recording form; but please tailor it to suit you. Experiment with these forms and try out designs of your own. However, always keep in mind the basic point of all this: that is, to help you stop hitting your brain with lots of negatives, to get a better perspective on things and start giving your brain a boost and some warmth.

Compassionate reframing

Ideas for generating alternatives are given in Chapters 9–11 and throughout this book. In Appendix 1 there are also various worked-out examples to offer you some more ideas – but these are only ideas. Sometimes it is helpful to take a few soothing rhythm breaths and focus on your compassionate self or image. You are trying to shift the position in your mind to where your thinking comes from – stepping into the compassionate frame of mind, as it were – and then from that position (or mind) starting to think about alternatives. You can also imagine compassionately trying to help someone, such as a friend you care for, to think in a different, more balanced way. How might you focus on strengths and courage, on coping and getting through? What would your voice tone be like? *The key is to shift position.* You will be very familiar with what your threat, loss and critical mind says, because that part of you will be active a lot of the time, but can you tune in to your compassionate mind, attend to it and develop it? Writing things down can give you the space and distance to start to do this.

Compassionate letter writing

There is now increasing evidence that writing about our feelings, expressing and exploring our feelings in writing (so-called *expressive writing*)¹ can be very helpful for some people. Indeed, we can put into words on paper things we might struggle to think about in our heads or express to other people. We will explore some types of writing here so that you can see which one helps you.

Writing about oneself

Choose what you want to write about: your life in general, or a particularly difficult time in your life that you had trouble coming to terms with, or problems that you are experiencing right now. The idea here is to express your thoughts and feelings on paper, writing about what has happened or is happening to you. Imagine that you're writing to a very compassionate person who completely understands what you feel.

Sometimes writing like this may stimulate different feelings in us. Again the key here is to go step by step and explore what is helpful to you. If you feel that there are things that you really don't want to face on your own, be honest about that and think about whether you want to obtain professional help to guide and support you, or talk to a friend. Remember all these exercises are intended to be helps and guides for you, and you'll need to judge just how helpful they are for you.

Another approach to writing is to begin to think about yourself and your feelings

from different perspectives. Because we use different aspects of our minds when we write, we can sometimes find that in the process of writing, new insights and meanings emerge in our minds that help us clarify things. Practising doing this can help you access aspects of yourself that may help you understand your feelings better, learn how to tolerate them without fear or worry of acting them out, and perhaps tone down more depression-focused feelings and thoughts. But keep in mind what I have said many times before – this is an invitation, a ‘try it and see’.

Writing about yourself from another’s point of view

Sometimes it is useful to try shifting perspective on how we see ourselves. One way of doing this is to write a short letter about yourself, from the point of view of someone close to you who cares about you. I’m going to use the example of a fictitious person we will call Sue, but when you write your letter substitute your own name, of course. Such a letter might include:

- *I have known Sue for about twenty years. To me, he/she has been _____*
- *I find Sue _____*
- *I think Sue struggles with _____*
- *I like Sue because _____*
- *Sue’s strengths are _____*
- *It would help Sue if she could _____*

This exercise is designed to help you develop the habit of considering other perspectives on yourself. If you like, show what you have written to someone you are close to and trust, and see what they think.

Some people find this very helpful, others do not. One person noted that ‘I actually don’t know anybody that well who would be able to write in detail about me.’ So here you might want to *imagine* a friend, and what you would like them to say about you. If you find it is too easy to dismiss positives then you might want to try practising some of the imagery exercises we talked about in Chapter 8, or the behavioral work in Chapter 12.

Writing compassionately to yourself

In this exercise we are going to write about difficulties, but from the perspective of the compassionate part of ourselves. There are different ways you can write this letter. One way is to get your pen and paper and then spend a moment engaged with your soothing breathing rhythm. Feel your compassionate self. As you focus on it, feel yourself expanding slightly and feel stronger. Imagine you are a compassionate person who is wise, kind, warm and understanding. Consider your general manner, voice tone and the feelings that come with your ‘caring compassionate self’. Adopt a kindly facial expression. Feel the kindness in your face before moving on. Think about the qualities you would like your compassionate self to have. Spend time feeling and gently exploring what they are like when you focus on them. Remember

it does not matter if you actually feel you are like this – but focus on the *ideal* you would like to be. Spend at least one minute – longer if possible – thinking about this and trying to feel in contact with those parts of yourself. Don't worry if this is difficult, just do the best you can – have a go.

When we are in a compassionate frame of mind (even slightly), or in the frame of trying to help a friend or someone we care for, we try to use our personal experiences of life wisely. We know that life can be hard; we offer our strength and support; we try to be warm and not judgemental or condemning. Take a few breaths then sense that wise, understanding, compassionate part of you arise. This is the part of you that will write the letter. So we write this kind of letter from a compassionate point of view. If thoughts of 'Am I doing it right?' or 'I can't get much feeling here' arise, note or observe these thoughts as normal comments our minds like to make, but refocus your attention and simply observe what happens as you write, as best you can. There is no right or wrong, only the effort of trying – it is the practice that helps. As you write, create as much emotional warmth and understanding as you can. You are practising writing these letters from your compassionate mind.

As you write your letter, allow yourself to *understand and accept* your distress. For example, your letter might start with

I am sad. I feel distressed; my distress is understandable because . . .

Note the reasons, realizing your distress makes sense. Then perhaps you could continue with

I would like me to know that . . .

For example, your letter might point out that as we become depressed, our depression or a distress state can come with a powerful set of thoughts and feelings – so how you see things right now may be the depression view on things. Given this, we can try and step to the side of the distress and write and focus on how best to cope. We can write

It might be helpful to consider . . .

A second way of doing this is to imagine your compassionate image writing to you, and imagining a dialogue with them and what they will say to you. For example, my compassionate image might say something like

Hi Paul

Gosh, the last few days have been tough. Isn't it typical of life that problems arrive in groups rather than individually. It's understandable why you're feeling a bit down because . . . Hang in there because you are good at seeing these as the ups and downs of life, and that all things change, and you often say at least we are not in Iraq. So you have developed abilities for getting through this and tolerating the painful things.

You will note that the letter points to *my* strengths and *my* abilities. It doesn't issue instructions such as, '*You must* see these things as the ups and downs of life.' This is important in compassionate writing. You don't want your compassionate letters to seem as if they are written by some smart bod who is giving you lots of advice. There has to be a real appreciation for your suffering, a real appreciation for your struggle and a real appreciation for your efforts at getting through. The compassion is a kind of arm round your shoulders, as well as refocusing your attention on what is helpful

for you.

AN EXAMPLE

Here's a letter from someone we'll call Sally, about lying in bed feeling depressed. Before looking at this letter, let's note an important point. In this letter we are going to refer to 'you' rather than 'I'. Some people like to write their letters like that, as if writing to someone else. See what works for you but, over time, use 'I'. You could read this letter and substitute 'I' for 'you'.

Good morning Sally

Last few days have been tough for you so no wonder you want to hide away in bed. Sometimes we get to the point of shutdown, don't we, and the thought of taking on things is overwhelming. You know you have been trying real hard, I mean you haven't put your feet up with a gin and tonic and the daily paper. Understandably you feel exhausted. I guess the thing now is to work out what helps you. You've shown a lot of courage in the past in pushing yourself to do things that you find difficult. Lie in bed if you think that it can help you, of course, but watch out for critical Sally who could be critical about this. Also you often feel better if you get up, tough as it is. What about a cup of tea? You often like that first cup of tea. Okay, so let's get up, move around a bit and get going and then see how we feel. Tough, but let's try.

So you see the point here: it's about understanding being helpful, having a really caring focus but at the same time working on what we need to do to help ourselves.

Writing as you at your best

Another way to write these letters is to imagine the part of yourself you like, the self you would like to aspire to more of the time (as long it's not the aggressive kick myself past of course!). Then try to bring that 'you' to mind – recall 'you at your best', 'you as you would like to be' and then write from that part of you.

Guide to letter writing

When you have written your first few compassionate letters, go through them with an open mind and think whether they actually capture compassion for you. If they do, then see if you can spot the following qualities in your letter.

- It expresses concern and genuine caring.
- It is sensitive to your distress and needs.
- It is sympathetic and responds emotionally to your distress.
- It helps you to face your feelings and become more tolerant of them.
- It helps you become more understanding and reflective of your feelings, difficulties and dilemmas.
- It is non-judgemental/non-condemning.
- A genuine sense of warmth, understanding and caring permeates the whole letter.
- It helps you think about the behavior you may need to try, to get better.

Depressed people can struggle with this to begin with, and are not very good at writing compassionate letters. Their letters tend to be rather full of finger-wagging advice. So we have to work and practise being compassionate. The point of these letters is *not* just to focus on difficult feelings but to help you reflect on your feelings

and thoughts, be open with them, and develop a compassionate and balanced way of working with them. The letters should not offer advice or tell you what you should or should not do. It is not the advice you need, but the support to act on it.

Writing to others

Another way we can use letters is to express to ourselves our feelings about people. Usually these letters are not sent. If you feel you want to send them, it's best to keep them for a week or two and think carefully before you do anything about it.

The purpose of this letter is again to articulate your feelings. You can write about your needs or sadness, disappointment or anger, or how you want to be loved or things you find it difficult to express. The point about writing these things down is that we think in a different way when we write.

Writing can help in ways that allow us to make sense of things and come to terms with them in a different way. For example, Kim felt very angry with her mother who was a career woman. As a child, Kim had been looked after by a number of different nannies. For some years Kim felt under pressure to tell her mother what she felt. She also felt she couldn't have a genuine relationship with her mother until she cleared the air, and that she was being weak in not speaking honestly. However, we talked about this and the importance of taking the pressure off herself 'to prove herself' and confront her mother. She wrote some moving letters that were never sent, and at the end of the process felt that a lot of the pressure to confront her mother had gone. In a strange way this actually made it easier for her to think about having a conversation with her mother about the key issues. Kim came to see that the degree of anger she felt blocked her in many ways, because it was less about anger and more about wanting recognition from her mother that was important. The writing helped with the anger and then Kim was able to think about how to have a quieter conversation about the sadness in Kim's life because of the effects of her mother's career.

Grief

Sometimes if we are grieving it can help if we write letters to the dead person, saying goodbye or whatever else we want to say. Goodbye letters can sometimes be quite emotional but also helpful in articulating and expressing our feelings.

As with all these exercises, take one step at a time and only do things that are helpful for you, or that you can see will be helpful if you stick with them. If you feel your grief is overwhelming then this might be a time to think about professional help from a counsellor or psychotherapist. Or simply take very small steps, but do it reasonably often, and build up.

Forgiveness

The last 10 years have seen a lot of research on forgiveness.² However, there is a lot of misunderstanding about it. Forgiveness is about letting go of our anger. The person we forgive we may never like, never want to see. We might never condone their actions. Forgiveness is simply putting down our weapons and our desire for vengeance, and walking away. We say, 'It ends here.' Of course there may be a lot of thoughts such as, 'I must not let them get away with it,' 'It is too unfair', 'I am weak

if I do not pursue this,' 'If I were a proper person I would do something about this.' The problem is that living with anger often isn't going anywhere and that is very depressing. The only person we are hurting is ourselves and our brain, because we are constantly stimulating threat systems in our brain. Anger that is unhelpful like this simply makes us feel powerless.

Forgiveness is a way in which you can bring peace to your mind. We could fill a whole book looking at how to work on forgiveness.² If you go on to the Internet you will be able to explore lots of sites on forgiveness. Check them out and see what works for you; some are interesting and helpful, and some not. But at a straightforward level, forgiveness letters are simply ways to help you acknowledge your anger and upset and forgive, let go, move on, walk away. As one patient told me:

I realized I had spent a lot of my life hating my mother and yet also wanting her to love me. She just wasn't up to it. When I realized that actually she was quite a damaged person and simply wasn't up to being as I wanted her to be, I felt more sorry for her and able to forgive her. To be honest I pulled back quite a bit and I think she would like me to have seen her more, but I found a comfortable distance for me. Recognizing this and letting go of my anger and my need set me free. And you know, wherever she is now (she died a few years ago), I genuinely hope she's happy.

Importantly, keep in mind that the point of these letters is not to stir up difficult emotions but to be compassionate about them and learn how to think about them in compassionate and balanced ways.

Gratitude and appreciation

So far we have rather focused on writing about difficult things. However research has also shown that it's very helpful if we can spend some time thinking about things we appreciate, like and feel gratitude for.³ When we are depressed it can be quite difficult to have feelings of gratitude. Nonetheless if we focus on those feelings it will stimulate parts of the brain that are associated with positive antidepressant feelings. You can start by thinking of a person or key phase in your life, or someone who is showing you some kindness no matter how small, and think about gratitude. The feeling of gratitude is not a grudging or a belittling feeling at all, but a feeling of pleasure and joy that the other person was there and helped you in some way.

Gratitude is not associated with a feeling of obligation. The moment we feel obligated by somebody else's kindness it is difficult to feel gratitude. Focus on the behavior. One patient noted that although there were things that angered her about her husband, just focusing on her gratitude for him helped her feel more balanced and happier.

The same goes for appreciation. Take your pen and a fresh sheet of paper, and write about the things you appreciate and like in your life. They might be quite small things like the first cup of tea of the day; the blue of a summer sky; certain television programs; the warmth of your bed; a relationship; or part of your job – absolutely anything that gives you feelings of appreciation and liking. Notice how we often let these pass. Bear in mind why you are doing this as an exercise – it is to balance up your systems and to stimulate part of your brain that will help you counteract the feelings of depression. Recall that depression will force you into a corner of your mind so that you always have to walk on the shadowy side of the street, so we have

to practise refocusing.

KEY POINTS

- To combat depression, we can call on different parts and abilities of ourselves: our rational minds and our compassionate/friendly minds. Writing helps us slow down and think in different ways.
- By calling on these aspects of our minds and trying to activate them, we are making our brains work in certain ways that can counteract depression.
- We can learn to write about our difficulties reflectively and with compassion by putting ourselves in the compassionate frame of mind when we write. This can take practice. Using a letter-writing approach can be helpful.

EXERCISES

Exercise 1

Write down your depression thoughts about a particular situation. Look at them carefully.

As you think about alternative ideas, take a rational/compassionate approach. Try thinking about what you might say to a friend who is in a similar situation. You might also consider how you think when you are not depressed.

To begin to generate alternative thoughts, look back at the ideas on pages 187–9 and focus on:

- What is it helpful to attend to (e.g., from memory or in your current situation). Remember the old saying 'is the glass half full or half empty?' – practise attending to the half-full aspects too.
- What is a fair, logical or reasonable way to think and reason?
- What would be the helpful and supportive things to do in this situation?

Exercise 2

Write some compassionate letters for yourself, or engage in writing that expresses your feelings.

Even if you don't have much faith in the alternatives you think of at first, the act of trying to generate them is an important first step. As with all exercises it is what you think will be helpful to you that is key, because different people find different things helpful. Make sure that all of your efforts to help yourself meet the 'friend and compassion test'. This means that any of your alternative thoughts are considerate, helpful behaviors that you would be prepared and pleased to offer to friends and that you can see are evidence of compassion. Logic and common sense is not always useful to us; it's when we feel it is helpful in our hearts that matters.

Changing your behavior: A compassionate approach

As we saw in earlier chapters, the depressed brain state can be a kind of ‘go to the back of the cave and stay there’ state. We want to pull the covers over our head and wish the world would go away. When we feel like this it helps to take a compassionate approach: in other words, to be very understanding of such feelings but also to think what might be triggering this feeling and how to break out of it. Maybe we have been working too hard and are exhausted, or maybe life events, setbacks and conflicts have taken the wind out of our sails. Sometimes a mild depression tells us we are exhausted and we really need to find a way to slow down and get some rest, let our bodies recuperate. Humans are like other animals – we need chill-out time. It is amazing how, when people take longish breaks from work, they often say they feel themselves slowing down, and the pace of life is easier. We must admit to ourselves that, through no fault of our own, we are living in a ‘rush rush, hurry hurry’ society where we can get rather exhausted. Learning to take time out, respect our body and rest it as much as possible is important, and I agree – it is easier said than done. In particular, one of the problems of being a single parent is the sheer workload, and demands that can be exhausting. If burnout and exhaustion are behind the depression, it’s important to see this and to address it in appropriate ways – without blaming oneself for being tired!

However, as we get depressed we can also stop doing various activities and disengage, and this adds to a depression cycle rather than helping it. We find resting is not helpful. When we are depressed, daily activities can seem overwhelming. In these situations it can be very useful to *operate against the pull of depression*. We need to encourage ourselves to do more not less, but the emphasis is on *encouraging* not *bullying* ourselves. This helps us to activate our drive system. It helps if we organize activities in such a way that they can be approached step by step. In the last 10 years or so therapies for depression have been developed which focus specifically on changing behavior.¹ There are also self-help books dedicated to this type of ‘change your behavior, change your mood’ approach.² It’s important, though, that you see this as helping you, not just as putting on a mask and carrying on regardless.

Tasks and goals

When therapists are trained, they are often taught to focus on three things: the bonds and relationships between patient and therapist; the tasks that need to be undertaken; and the goals and aims of the therapy. In helping yourself to get out of depression,

you can take the same approach. The bonds and relationship you have with yourself have been the focus of earlier chapters, so now let's look at tasks and goals.

Tasks

Often, as we move forward out of depression, there are various tasks that we can set for ourselves on our step-by-step journey. Here are some examples:

- Learn to tune into and monitor your thoughts and feelings.
- Write down your thoughts and feelings.
- Try tape recording ideas that are good alternatives to your negative thoughts on a tape. When you feel down, play these alternatives to yourself.
- Learn to be honest with yourself.
- Learn how to take big problems and break them down into smaller ones.
- Set yourself small things to do that operate against the depression each day.
- Increase the time you spend talking with friends.
- Make the phone calls you need to make to sort things out.
- Learn to be more assertive or less self-attacking.

These are not easy things to do, so you may have to work hard. When we are depressed our thoughts and feelings are very dismissive – they may say things like, ‘This won’t work for me; don’t be silly; I can’t do it; can’t be bothered; I’m too angry; it’s too difficult’. These are all very common thoughts. The way to deal with them is to expect them, to notice them, but focus on the task anyway. If you put a certain time aside, e.g., five minutes, plan to focus your time on the task. You might also think about whether this feeling is actually linked to angry rebellion and you are really saying, ‘Oh, sod it. I just don’t want to do it, so why should I!’ If that is true, then honestly acknowledge it – be compassionate and understanding of such feelings, but then take a breath and think about how to actually help yourself move forward. Think also that there may have been many times in life when you predicted that things would not work out but they did.

Goals and commitments

Having small and achievable goals can be helpful as these are the things you want to achieve. At first, depressed people usually just want to feel better. But this large goal needs to be broken down into smaller ones. These smaller goals might be:

- To do a little more each day.
- To be more assertive with some other person(s).
- To spend more time on something I enjoy.
- To join a club or charity where I can get involved with other people and feel useful.
- To spend more (or maybe less) time with my children.

The most important commitment is to put effort into transforming your depression by training your mind in helpful, compassionate *actions*. You do this in the knowledge that:

- The way our brains have evolved over many millions of years can be very tough on us and give

a host of unpleasant feelings and moods.

- That is absolutely not our fault – we did not design our brain, choose our genes, or how our early relationships shape us.
- But it is up to us to try as best we can to work with our minds to change our mental states.

Commitment is linked to the value we put on things. For example, if I ask you not to express your anger for a week, or to go out even if you're depressed, you might be uncertain. What about if I offered you £10? Okay, £100? Not enough? Okay, £1 million. Of course I can't do that, but think about it – if there is a really big payoff you might put a lot of effort into something. We have to be honest about this. Like a person training to get physically fit, some days will be harder than others – but the clear goal keeps them going. For working on a depressed state of mind, focus on how it will help you to get better and really make that your goal – think of all the benefits – imagine (and see) yourself as 'feeling better' and what you are doing now you are better. It is easy to let these slip from one's mind when it gets tough. It can be useful to set yourself a couple of goals at the beginning of each day or week. Start by setting small goals – the smaller, the better. If things are difficult or you don't reach your goals, ask yourself some questions.

- Were the goals too ambitious?
- Could I have broken them down further?
- Did I run into unexpected problems?
- Did I put enough effort into achieving them?
- In my heart of hearts, did I think that achieving them wouldn't really help?
- If it did not go as I wanted, am I being compassionate with myself?

Behavioral experiments

Many therapists encourage us to try what we call behavioral experiments. This means trying out different things, keeping an eye on what works for us, how we might do things differently to make them work better for us, and tailoring them to our needs. This does not mean doing things simply because we're told to, but trying to see the point of what we're doing. For example, if you want to get physically fit you might go to the gym and really push yourself even though it's not entirely comfortable. You learn what works for you and put up with the discomfort because you understand what you're trying to achieve. Indeed, the discomfort may actually inspire you because you feel it is helping you move forward in your goal of 'getting fitter and stronger'. We can approach depression like this too.

Take staying in bed. If staying in bed helps you feel better, all well and good, but often in depression it does not. We simply use bed, not to rest and regenerate our energies, but to hide away from the world. Then we feel guilty and attack ourselves for not doing the things we have to do. When you are lying in bed, you may tend to brood on your problems. Although bed can seem like a safe place to be, it can actually make you feel much worse in the long run. The most important step is to try to get up and plan to do one positive thing each day. Remember, your brain is telling you that you can't do things and to give up trying. You will slowly show that part of yourself that you *can* do things, bit by bit.

Occasionally, however, because depressed people often bully themselves out of

bed with thoughts such as, 'Get up, you lazy bum, how can you just lie there?', it can be useful to try the opposite tack. This is to learn to stay in bed for a while, at least one day a week, and enjoy it – read a magazine or listen to the radio and allow yourself to feel the pleasure of it. To practise being able to lie in bed without feeling guilty can be helpful for some people. Imagine that you are exercising that pleasure area of your brain, which really needs exercise.

Designing experiments

It is useful to work on and against our depressive ideas by setting experiments: that is, testing things out and rehearsing new skills. A useful motto here is, 'Challenging but not overwhelming'. Remember – design your experiments – things to have a go at – to take you forward step by step, rather than rushing into something that has a high risk of failure. Don't worry if the steps seem too small. If things go a bit pear-shaped, remember it was just an experiment and think about how to learn from it.

Experiments don't always work out as we hope they will. When I was a shy young student at college, a good friend encouraged me to ask a woman to dance at our college dance. It was noisy, but I got my request across. She turned to her friend, looked at me, looked back at her friend, laughed – and they both got up and walked to the bar! Oh dear. On another occasion I had learned some assertiveness and was in a shop queue when an older man pushed to the front of the queue. People were irritated. I need to do something here, I thought. I'm a psychologist and an assertive one. I left my position at the back and said to the man, quite kindly I thought, 'Excuse me, look, I'm sorry but there is a queue.' He looked at me and then said, 'Why don't you eff off, you four-eyed git, before I smash your face in.' My response was of course to say, 'Absolutely – look – I'm off right now!' So even the best-intended plans don't always work out!

If we try things and they don't work out, we can try to find out why. Was there anything about it that was a success? For example, you did try and you can learn to cope with these setbacks and try again in the future. One can learn not to be so fearful of failing or rejection – it is unpleasant but nothing more. My college friend thought it was funny that the girls walked off but said, 'That's typical, you've just got to keep trying. Somewhere in the hall a girl will want to dance with you, you've just got to find her. On attempt 252 maybe.'

We also need to think whether we were attempting too much. Were our expectations too high? In the case of tackling the aggressive man the answer is probably yes – he was a big fellow, and I am by nature a coward. Did your negative thoughts overwhelm you? Did you really put the effort into it that you needed to?

People can generate and write down alternative thoughts and ideas and behaviors. They may be very casual about it and just look at the words without thinking their meaning through, or trying to put *feelings* of kindness and understanding into those alternatives. In the back of our minds might be a thought, 'This approach can't work.' So we stack the experiment against ourselves before we begin.

So we may need to use the courageous part of our compassionate mind to tell ourselves in a friendly, supportive way:

Look, I know this is hard, and yes, it is a shit being depressed, but let's not stack things against myself. Let's give it a fair go. After all, what have I got to lose? If I were helping a friend, I'd know how tough it is but I'd also encourage them to give it a go. Let's go

through this step by step.

Getting out of depression takes effort, and this is especially true if you are trying to help yourself. It is the same with getting physically fit. It would be no good putting on your trainers and running to the garden gate and back – you have to push yourself more than that (assuming you don't live in a stately home where the garden gate is a mile away). It is very understandable to find this tough going, and it may be that there are times when we need some extra help from friends or professionals. There's no point in berating ourselves if we've tried our best and have found it too hard.

Blocks to becoming active

To become more active, it helps to decide on a specific activity and the time you are going to do it. For example, go shopping at 10 a.m. on Tuesday. Visit a friend at 2.30 on Wednesday afternoon. When the time comes, go for it. Each day, do some things that invite you to operate against depression. Make a plan for the week, and when you get to the time do whatever it is you've chosen to do. Try to engage in each activity in a *spirit of encouragement and support*.

You may well have some extremely understandable but unhelpful or irritable thoughts: 'Nothing I do to help myself will help me – so it is not worth trying.' If you do, be compassionate and shift to your compassionate self (see pages 149–155). Recognize that all over the world depressed people think like this, because that is how the depressed mind thinks– so it is perfectly understandable to think like this. But it is only one possible pattern in your mind, so consider also:

- Am I defeating myself before I start? Probably if I am honest. Huff.
- Let's get helpful here and try to be supportive.
- Do I really have enough evidence to say this or that can't work, or is this just how I feel about it?
- What have I got to lose by trying? If I put effort into this and it doesn't work out, I'll certainly be no worse off and might have gained something.
- If I try, at least I'll know I made the effort even if things don't work out.
- I can go one step at a time. If I break my problems down into smaller ones, they may not seem so overwhelming. I don't have to try to do too much at once.
- I may feel better if I try to do something rather than nothing.
- I can praise myself for effort.

Now try this. Spend a moment on your soothing breathing rhythm and connect with your compassionate self, no matter how minimally (see pages 149–55) Read through these ideas (on page 253) with as much warmth, care and concern as you can, and as if you really wanted to help a friend. How do they seem to you now?

Learning how to do things we don't want to do

To reach our goals in life we often have to do things we don't want to. People who want to be successful at sport, playing an instrument or passing exams have to practise and study even when they don't want to. Many of us feel very anxious when we start learning to drive a car. When I started, my leg shook so much I could hardly

push in the clutch! However, we accept those things – because of our goal to be able to drive and be mobile. And of course there are many small things that we may not want to do such as getting up to go to school or college, studying for exams, going to work, or getting the children up and out for school. Even making the effort to socialize can seem like a hurdle.

Step 1: Develop your vision

When engaging in disliked activities, focus on the benefits of doing them (rather than the difficulties), and think about how you will feel if you complete a task. Think how your actions can take you nearer to your goals, while avoiding things won't actually help you get better – although you may temporarily feel less anxious (or whatever).

Karen felt tired and a little anxious about going to the shops. So she created in her mind a vision of herself coming home with the bags of food and making something enjoyable to eat with the family and tried to hold that in mind while doing the shopping. She saw that as an achievement. It really helps if we can think of a goal and commit ourselves to it. Otherwise what's the point of engaging in difficulties unless you can really see the benefits and focus on those? That's true for all things in life, of course.

Sue kept in mind how good she would feel in a few months when she had left her husband and worked through his threats. 'It was keeping that vision of being free and living alone, doing my own things, that helped get me through and take difficult decisions,' she said.

Step 2: Develop the feelings of support and helpfulness

Focus on creating inside you *feelings that will help you*. When engaging with activities you're not too keen on, spend a moment really trying to contact and create within you your compassionate self. Then take yourself gently by the hand and engage in the activity. When we talk about getting up to do things, this is not to bully you out of bed or into doing things but to encourage you to get up, because lying there and brooding on problems may only make you feel worse. Getting up and doing things takes you closer to your goal of recovery. But test it out, try it a few times and see how you go. Think about how you can make this 'acting against your depression' with kindness more effective for you once you understand the value of doing it.

Working on blocks to helpful compassionate behavior

Compassionate behavior is aimed to help you grow, develop, nurture and overcome difficulties in your life. It is very easy for us to view compassion and kindness as being about giving in, about not pushing ourselves, and *sometimes it can be this*. I am all for making life as easy as possible if it helps me. But we need to be wise about this because if we are honest sometimes backing off, giving in, or taking the easier route is going to make life much more difficult; that's not compassionate. David Veale and Rob Willson in their book *Manage Your Mood* have identified a number of obstacles to working on helpful and compassionate behavior.²

Doing things only when you feel motivated to do them

Sometimes that works, and there are times when we feel like doing things and times when we don't, but be honest with yourself if it's just avoidance. Will there actually be a time in the near future when you know you will be motivated? Maybe it is useful to act against this lack of motivation. Learn how you can do things even when you're not motivated because then you are free from the 'whimsies' of your motivational system. Learning to do things in an unmotivated way can be a useful skill.²

Waiting to feel better

If you are feeling very tired, then it is a good idea to check with your family doctor whether there could be a physical reason for your tiredness. Tiredness is one of the most common symptoms that present to family doctors today, so ensure you get the evidence that your tiredness is indeed related to your depression. Sometimes if you are recovering from a physical illness or you have been exhausted, waiting to feel better and allowing your body to recuperate is helpful. But at other times simply waiting to feel better is not helpful and the way to feel better is actually to do more things. For example, there is no point in saying, 'I will ride my bike or get fit when I feel fit and energized'. The reason for doing these things is because I don't feel fit and it is the doing of those things that makes me fit and energized (hopefully!). We must not put the cart before the horse.

Waiting for medication to work

You might think, 'My doctor told me I need medication; indeed this book has talked about depressed brain states, so I just need to wait for the medication to work.' Sometimes this can be helpful, but we can also change our brain states through our activities. Your medication will not retrain you, teach you, or help you build up your coping skills – only you can do that. These skills we are discussing here can help you now and in the future to put control back in your own hands. Your medication might work better if you also work against your depression.

When I have more confidence I will do more

This is also a 'cart before the horse' issue.² Think of any activity such as learning to drive. What comes first, confidence or your anxious practice? Confidence comes from the doing, not the other way round. If you have had confidence and have lost it I'm afraid the same applies; we regain confidence through the doing.

Frankly I can't be bothered

Who hasn't felt that from time to time? But in depression, sadly, it can be for most of the time. As I noted briefly above, if we're honest sometimes these feelings can be tinged with anger or, 'Why should I, it's too much effort.' We might feel angry with people around us, and fed up, and it's easy to withdraw from them. One of the difficulties for some depressed people is recognizing just how much anger or resentment interferes with their lives in all kinds of ways. Here again the trick is to act against that anger, and not to allow your anger to dominate your behavior, by

giving up or withdrawing. Acknowledge your anger honestly and then think of some activities that would help you. Be honest if you tend to ‘cut off your nose to spite your face’. This is actually rather common, so there is nothing to feel ashamed about once you’re honest about it. Keep in mind to be honest but also kind about these thoughts and feelings – they are all very human things, really.

Breaking down large tasks into smaller ones

Depressed brain states can tone down some of our thinking abilities. The depressed brain state interferes with our planning and straight thinking abilities, so we have to plan things in different ways than we might normally do. Suppose you have to go shopping. It would be natural for a depressed person to think about all the hassles before they start, feel overwhelmed, and not go. Okay, we know that is how depression thinks so how can we act against it? One way is to practise the step-by-step approach and focus on one step at a time.

So first look in your cupboards and make a list of what you need. When you’ve done this, give yourself some praise. Think of a phrase that’s fun for you, such as, ‘Okey-dokey – done’ or, ‘Okay, that’s cool – I’ve done step one.’ Keep an eye open for angry thoughts like, ‘But this is so simple I should be able to do it easily.’ Well, if you weren’t depressed you would, just as if you didn’t have the flu you could probably run easily, and if you didn’t have a broken leg you could probably walk upstairs easily. The brain state of depression makes our daily activities difficult, so acting against it is hard work. Keep in mind that after all, you are one step further ahead than you were before you made the list.

Next, get your bags and other things together to go to the shops. On the way, focus on the fact that you are now prepared for shopping. Again notice the various thoughts that can pop into your mind about how difficult this is, how tired you feel, how you probably will forget something. Keep in mind that we expect those thoughts because that’s how depression thinks. Be mindful and notice the thoughts, recognize them as expected and natural, and then refocus your attention on your activity and intention. To the best of your ability, be kind and gentle with those intrusive thoughts and feelings.

When in a shop, work your way slowly around until you have everything on your list. Oh, they have run out of a key thing you wanted? Note your frustration, recognize it as natural, be kind to it and then refocus your attention on how best to cope with that annoyance and the thing you wanted not being in this shop. Notice if depression gives you a stream of thoughts ‘I knew this would happen; it is typical; what a useless shop; why does this always happen to me!’ And of course we don’t need to feel depressed to have those thoughts! Again be mindful – notice them, smile at them and return your attention to the task at hand – be kind to these thoughts – don’t fight with them or try to stop yourself having them. Remind yourself that millions of people throughout the world are probably having the same thoughts as you.

We have used shopping as an example, but of course you can use any activity you like. Here are the steps:

- Break the activity down into small chunks or steps.
- Notice what would be helpful to do for each step.
- Notice distracting thoughts and feelings; treat them kindly but give focus to doing the activity.

- Smile to yourself when you achieve each step.
- Notice frustrations along the way; be kind to those frustrations and refocus your efforts on achieving your goal.

As with most things in life, practice helps.

Planning positive activities

Often, when we feel depressed, we think we have to do all the boring things first. Sometimes, boring chores are unavoidable, but it will really help you if you also plan to do some *positive activities* – simple rewards that give (or used to give) you pleasure. For example, if you like sitting in the garden with a book, going to visit a friend, taking a walk, or swimming, then plan to do these activities.

Sometimes depressed people are poor at including positive activities in their plans for the day. All their time is spent struggling to get on top of the boring chores of life. They may feel guilty going out and, say, leaving the washing up undone. But we need to have positive activities. If we don't, it is like drawing on a bank account without putting anything into it. The positive things you do can be seen as depositing money in your account. Each time you do something that gives you pleasure, no matter how small that pleasure is, think to yourself: that's a bit more in my positive account. Another way to think about it is stimulating these emotion systems inside of you. They need to be 'worked', like muscles do. If we don't stimulate our positive emotion systems then we are not stimulating the cells in those systems and eventually they might not be able to give us the positive feelings we want. This is why we can think about what we are doing as a kind of *physiotherapy for our brains*.

If you think like this it will help you get around blocks to doing positive things, such as thoughts like 'I do not deserve this', 'I am being selfish', or 'I must attend to other things first'. We may have grown up being told we deserve this or don't deserve that. But this is not about deserving, it is about exercising your body and brain to help them work more effectively for you. You can always choose not to do positive things once you are free to.

In Chapter 7 we explored focusing on things you like and enjoy, and learning to appreciate things. To start with these are often small things such as your first cup of tea of the day. Learning to train our attention to focus on pleasures is important. For example, you might like walking, but even though it is a beautiful day, because you are not practising focusing your attention on it, your mind is full of your problems and how you are not feeling so good. When engaging with positive activities, focus your attention on what you are enjoying, no matter how small that experience of enjoyment is. Have a go for a while and see what happens for you.

Coping with boredom

Some depressions are related to boredom. Through no fault of our own our lives have become repetitive and boring. Sometimes this appears unavoidable. However, again the key issue here is to diagnose boredom and then take steps to challenge it.

One of my patients had gradually slipped into a lifestyle that involved going to work, coming home, watching TV and going to bed, having given up meeting friends and planning activities with them. Slowly, step by step, he began to think of things he would *like* to do, and then tried to see if he could do at least some of them. One thing was joining the local football club and getting involved as a social member. At first

he found making the effort to get to meetings tiresome, but he got to know a few people and that encouraged him. Another was joining a local charity group and helping with fund-raising.

A recent patient experienced life as rather meaningless, but had the idea that somehow life should be meaningful all by itself. But meaning is something we need to create, and we do this through our activities and commitment to goals. Finding things you can do to help others can often make life meaningful. Meaning rarely comes from simply wanting to pursue pleasures.

Women who feel trapped at home with young children are particularly vulnerable to boredom and lack of adult company. We are a highly sociable species, and sharing and talking with others is important for our well-being. Again, the main thing for people in this situation is for them to recognize that they are bored and begin to explore ways of getting out more and developing new contacts. They could perhaps contact mother-and-baby groups, and ask their friends about other activities. If social anxiety is a problem, people who are depressed like this could try to do a little more each day in making outside contacts and/or contact their family doctor to ask if there are any local groups who might be able to help them with social anxiety and getting out more. The reasons that we may have fallen into a lifestyle where we are not stimulating our positive emotion systems enough may not be our fault at all, but we will have to try to take control over the situation, step by step.

Increasing activity and distraction

Sometimes, when people feel very depressed or uptight, they can also feel agitated. At these times, trying to relax does not work. Their mind won't settle down to it. Then they need to distract themselves with a physical activity. Any kind of activity – digging the garden, jogging, aerobic exercises, decorating and so on – can be helpful. Physical activity can be *especially* useful if you are tense with anger or frustration.

Creating personal space

Occasionally there may be a problem in creating 'personal space' – that is, time to be spent on oneself. We can feel so overwhelmed by the needs of others (e.g., the family) that we allow no 'space' for ourselves. We become over-stimulated and want to run away. If you find that you need time on your own, don't feel bad about it but see it as important to think about. Talk to those close to you and explain this. Make it clear that this is not a rejection of them: rather, it is a positive choice on your part to be more in touch with yourself.

Many people feel guilty if they feel a need to be alone doing the things that interest and are important to them, but it is important to negotiate these needs with loved ones. Most importantly, do not assume that there is anything wrong with you for wanting space or that there is necessarily anything wrong with your relationships. Relationships can become claustrophobic from time to time. If you know that there is space for you within your close relationships, this may help to reduce possible resentments and urges to run away. Keep in mind that we humans evolved into small groups *living in the open*. Thousands of years ago we would not be trapped in a house with one person or children. It is very natural for us to want to spend time alone. Carol found that wherever she went in the house sooner or later one of the family would have a request: 'Where's my shirt?', 'Where are you, mum?' She

couldn't even get any peace in the loo! It helped to explain to her family that she needed rest time and this would be helpful to her.

Knowing your limits

Depressed people can become exhausted from overwork and then can't cope with the demands placed upon them. They notice that they were failing and becoming overwhelmed, feel ashamed about their failings and become more depressed. Most depressed people are real battlers but sometimes they allow themselves to over-extend because they can't say 'no'. To be frank that is not helpful to you. I have certainly got caught in that one too.

Think of ways that you might replenish yourself, but most importantly, don't criticize yourself for feeling burned out. Acknowledge it honestly and think through steps that might help. Are there enough positive things in your life? Can you do anything to increase them? Can you speak with others about your feelings and seek their help? Can you take time out or pass on some of the chores? Burnout can occur if we have not created enough personal space. Limits are personal things and they vary from person to person and change from time to time and situation to situation.

Looking after our bodies

Dealing with sleep difficulties

Sleep varies from person to person. My daughter and I have never been particularly good sleepers, whereas my wife and my son can fall asleep almost anywhere. In addition, the ease of getting to sleep and our need for sleep change as we grow older, so our sleep patterns are personal to us. Although it's annoying, try not to worry about not getting enough sleep. Famously, Margaret Thatcher only slept for four hours a night! Sleep problems can take various forms. Some people find it difficult to fall asleep, others wake up after being asleep for an hour or two. Other people wake up in the early hours, and there are also those who sleep extremely lightly.

Think of sleep as another behavior that needs managing. A milky drink before bed may help. Make sure that your bed is comfortable and the room well ventilated. Plan for sleep. Don't do what I used to, which was to work late into the night and then find I couldn't sleep because my head was buzzing with the things I had been working on. In planning for sleep, think about relaxing (and try to relax) half an hour to an hour before bedtime. Listen to relaxing music or do a relaxation exercise. If possible, read a book that takes you out of yourself (but not one that scares you or is particularly mentally involving). Avoid arousing (exciting or scary) TV programs. If appropriate, ask your partner for a soothing massage. Take gentle exercise during the day.

Among the things to avoid is alcohol. Having a drink (or two) may seem helpful, but usually isn't. It leads to disturbed sleep patterns, and you may wake early in the morning with mild (and, if you drink heavily, not so mild) withdrawal symptoms. Catnaps during the day can disrupt night sleep. If I sleep for longer than 15 minutes during the afternoon it can really mess up my night's sleep. If you wake early, get up and avoid lying in bed, ruminating on your difficulties. As a poor sleeper, if I wake

early I tend to get up and work. Of course, at times this leaves me feeling tired, but I have come to accept this as my style. If your sleep pattern is very disturbed, you may find an antidepressant helpful. Some people have found that going without sleep for a whole night and not catnapping the next day can help lift their mood, but this is best done under supervision. There are some good self-help books on the market for sleep problems. Do discuss with your family doctor though, because sometimes tiredness and not sleeping can be linked to things like anaemia (or other physical reason) and a dose of iron tablets might help.³

Body work

An important aspect of compassionate behavior is looking after, nurturing and caring for your body. Your body is like a garden, and to function well it needs looking after. It can become exhausted and *needs pampering*. Learn to care for your body and treat it with respect. Teach it how to relax, exercise it and feed it good things – not junk food and high-sugar foods, especially if you are depressed.

I always advise trying to find a sympathetic family doctor with whom you can have a frank and open discussion about your depression. In 1992 the Royal College of Psychiatrists in Britain mounted a 'Defeat Depression' campaign to increase the awareness and skill of family doctors in this area of psychological problems.

Very occasionally, depression can arise from a number of physical conditions. These include:

- problems with the thyroid gland
- anaemia
- diabetes
- chronic fatigue syndrome (CFS; also known as ME)
- vitamin deficiency (e.g., B12)
- hormone problems
- stroke
- complications with other medications.

It is important to have these and other things screened out as soon as possible. However, one should also recognize that most depressions are not triggered by a major physical condition, although there may be more subtle problems.³

Changing the way you treat your body

Eat a healthy diet and drink plenty

People who are depressed often have a very poor diet. Work out a balanced diet including fresh fruit and vegetables and a high percentage of carbohydrate (e.g., pasta, bread, potatoes). This is because these foods release their energy slowly and may help to boost certain chemicals in the brain that are depleted when we are depressed. You may wish to take advice on this.⁴

There is increasing evidence that weight loss itself can affect various brain chemicals. Consider if your depression came on or got worse as you lost weight. Some research has also shown that eating large amounts of sugar and other refined

foods might increase irritability in some people, so try cutting out cakes and other sweet things.

Some people like to take extra vitamins. The evidence for these helping depression is not clear, but provided you are not doing yourself any harm (e.g., too much vitamin A can damage your liver), these may work as a placebo if nothing else – that is, you may become less depressed simply because you believe in the vitamins, not because they have actually had a direct effect on your brain chemistry. A sympathetic family doctor will advise you on this.

We often don't drink nearly enough and so toxins can build up in our bodies making them feel sluggish. The ideal is two litres a day so that your urine is fairly clear but don't drink too much too quickly. Drinking water can also help weight loss. Again it is very useful to talk to your doctor about this. If anxious, avoid the stimulating caffeine drinks of coffee and even tea, and try green teas.

Supplements

Because depression is so common in our societies, the Internet is full of remedies. These include things like omega-3 fatty acids, folic acid, *S*-adenosyl methionine (SAM-e), St John's wort and many others. Evidence that some of these may be helpful is gradually accumulating.

The problem is that the quality of products obtained via the Internet can't be guaranteed. Some of these supplements can interact with medication or have side effects. So if you want to explore them you will need to discuss things with a qualified person, usually your family doctor or a nutritionist. Provided you obtain appropriate professional advice, then experimenting and seeing what works can be helpful.

As with much in this area, we desperately need more research. We also know that people can have very individual responses to all kinds of medications and supplements. What is helpful for one person may not be helpful for another, because biologic -ally we are all slightly different. Evidence tells us that many people pursue the alternative therapies for depression, but if you choose to explore this path, tread cautiously.³

Taking exercise

There is increasing evidence that exercise can be very beneficial for mild to moderate depressions because it tends to boost the production of certain chemicals in the brain. A patient of mine who had a bipolar illness (and was taking lithium and an antidepressant) found that if he woke up in the morning feeling down, a vigorous swim in the local pool helped to lift his mood. When we become depressed we tend to do less, and if you can encourage yourself to take exercise, this can be helpful. It may give you a sense of achievement, in addition to being good for you and boosting certain brain chemicals.

Reducing your alcohol intake

Alcohol can have a depressant effect, and it is usually helpful to reduce your intake, especially if you tend to drink to control your moods. Sometimes people use alcohol to get to sleep; as we have seen, this can be detrimental. Altogether, alcohol is a bad

way of managing stress and depression.

Stimulants and other drugs

If you are taking stimulants, try to stop. This applies even to mild stimulants such as coffee. Occasionally, I've found that some of my depressed patients drink vast amounts of strong coffee, sometimes more than 10 cups a day. Many stimulants can have depressant or anxiety-increasing side effects.

If you are using illicit drugs, try to get off them as they will not be doing your body any good. Some cannabis smokers lose motivation and become depressed and apathetic, and if there is an underlying sensitivity, it can also lead to more serious mental health problems. In fact, abuse of all drugs, including painkillers, needs to be considered here. If you are taking a lot of painkillers, you should see your family doctor and plan to reduce your intake.

Tranquillizers

Taking the odd tranquillizer from time to time can be helpful. However, if you have been using tranquillizers for a long time, you should think about coming off them. You must not come off them too quickly, however, but rather reduce your intake slowly. It is important to obtain medical advice from your family doctor, who might refer you to a psychiatric nurse or psychologist. There are also self-help groups and books to help with tranquillizer withdrawal.

Learning to relax

Sometimes this is easier said than done. Have a look back at pages 130–2 for some suggestions. There are also a variety of books and self-help tapes on relaxation on the market, as well as classes and groups. Explore these and see if you can find one that suits you.

Overview

Compassionate behavior means engaging the world in a certain kind of way, which often means acting against our depressed feelings. For this we can develop compassionate courage. We also need to treat our bodies carefully; after all, they are the foundation for many of our feeling states. I suspect that in the years to come we will learn much more about the relationship between our diets, various additives in our food, the chemicals in the atmosphere and how these effect our moods. But we can try our own experiments. Provided you discuss with your family doctor or a qualified professional then you may want to experiment to see if certain types of change in eating, exercise or supplements help you. My view about depression is that it affects mind and body and we should treat them both kindly.

KEY POINTS

- There are many forms and causes of depression.
- Because of these differences we need to have a variety of different approaches to depression.
- It can be helpful to plan activities step by step. Break problems or tasks down into simple steps and follow

them one at a time.

- Include some positive activities in your life. At times, you may need to increase your social contacts, at other times reduce them to create personal space. Much of this is about working out your own needs.
- The type of thoughts we have can affect the way our brains work. Sometimes, certain thoughts can be controlled by distraction.
- Don't assume that you have to become an inexhaustible supplier of good works. No one can be. Learn to work out your limits. If you think that there are very few things you can't cope with, the chances are that you are not working within your own limits.
- Finally, treatment often needs to be aimed at how our bodies are working. It may require us to take seriously the possibility of using an antidepressant to help us get going again. We may need to change our lifestyles (e.g., take more exercise, improve our diets, cut out the coffee, learn how to relax, distract ourselves).

EXERCISES

Exercise 1

- Make a list of the points in this chapter that you think are relevant to you.
- Clarify in your mind:
 - How are you treating your body?
 - How do you organize your activities? Can you plan to do things step by step?

Exercise 2

Make a list of the positive things you would like to include in your life. These can be quite simple: for example

- I would like to see my friends more.
- I would like to go to the movies more.
- I would like to have more time to myself.

Consider ways that might make some of these things happen.

PART THREE

Developing Supportive Relationships with Ourselves

Stop criticizing and bullying yourself: Treating yourself with compassion

Humans are able to think about themselves as if they were thinking about someone else. We have feelings and make judgements about ourselves; there can be things that we like or dislike; we have relationships *with ourselves* that can be healing or unhelpful and even abusive. If we are honest we can think or say things to ourselves, and feel emotions (anger and contempt) towards ourselves, that we wouldn't dream of directing towards other people. We recognize that if we treated others like that it would be abusive. But we treat ourselves like that, especially if we fail in some way, make mistakes, do things we regret, or just feel bad. At the times we need compassion, we actually give it to ourselves least. Because we believe that somehow being critical, harsh, disliking or even hating ourselves is deserved or can be good, we continue to do it. However, self-criticism, especially feelings of anger, frustration or self-contempt, is bad for your brain (see pages 28).¹

This chapter encourages you to develop a more helpful and considerate response to yourself. Your sense of yourself is always with you, from the moment you wake up to the moment you go to bed. It makes sense to learn how to have a relationship that is friendly, supportive, healing and stimulates the positive emotion systems in our brain rather than the threat systems.

In depression, thoughts and feelings about oneself can become very negative. I say 'can' because this is not always the case. For example, I recall a woman who became depressed when the new people who moved in next door played loud music into the early hours. She tried to get the authorities to stop them, but although they were very sympathetic, they were not much help. Slowly she slipped into depression, feeling her whole life was being ruined and there was nothing she could do. However, she did not think her depression was her fault or that she was in any way inadequate, worthless, weak or bad. Her depression was focused on a loss of control over a very difficult situation.

Sometimes depression can be triggered by conflicts and splits in families or other important relationships. The depressed person may feel defeated and trapped by these relationships, but not to blame for them. Sometimes depressed people feel bad about being depressed and the effect this is having on them and others around them, but they do not feel that they are bad or inadequate as people; they blame the depression.

Nevertheless, many depressed people have a poor relationship with themselves. A poor relationship with oneself can pre-date a depression or develop with it. This chapter will explore the typical styles of 'self-thinking and feeling' depressed people engage in, and consider how our relationship with ourselves can be improved. All the styles discussed here can be seen as types of self-bullying. As you will see, we can

bully ourselves in many different ways.¹

Social comparison and self-blame

We live in a world that is very judgemental and treats us rather like objects.² At school, being chosen to play on the football team, getting our first job and so on, we are surrounded by people who can do better than us, who we feel are more attractive, more capable, and so on. What is worse – in schools, through our media and in workplaces, we are constantly encouraged to compare ourselves with others – are we as good as them; as clever, attractive or slim; or as wanted? My research has looked at how people can feel under pressure to strive to keep up and avoid being judged as inferior. You will not be surprised to learn that the more people feel under pressure to avoid being seen as inferior compared with others, the more vulnerable to stress, anxiety and depression they are.³

Social comparison can be helpful because it helps us copy each other – adopting the same values, wanting the same things and trying to improve ourselves. If we fail at an important task, such as an exam or the driving test, we can feel better if we find out that others have failed too. We might feel guilty at feeling pleased they failed too, but it's only natural to feel better when you think you're the same as others.

Depressed people can feel that others are more talented or lucky. As children they may have felt that parents favoured their siblings, or they may feel that their siblings had an easier time growing up.⁴ Sometimes depressed people have many un-resolved problems about these early relationships. They may feel that they have always lived in the shadow of a sibling – were less bright, less attractive and so forth. Sometimes parents and teachers have compared them unfavourably with others – 'Why can't you be like Sam or Jane' – or maybe they had parents who were always comparing them with others. For example, when Jane came second in class, her father's reaction was always disappointment: 'What's the matter with coming first?' His motto was, 'Second is the first loser'. Such children grow up in an atmosphere of constant striving to compete with others to win parental approval; they never feel good enough. If you look back at pages 28–9 you can see how this can stimulate the drive system by trying to be 'better and better or have more and more' and never being satisfied or content. That is not your fault, but it is something you might wish to work on, to learn how to be more content and understand the roots of your striving and social comparison. Maybe it is searching for love and acceptance that underlies your striving?

Jim went to university and did well, but his brother Tom was a more practical person and not cut out for the academic life. However, instead of being happy with himself, Tom constantly compared himself with Jim and felt a failure. He would say, 'Why couldn't I have been the bright one?'

Babs' mother was often ill, and as the older daughter she took on responsibility for caring for her. However, she didn't feel appreciated for the role and grew up feeling secretly resentful, but always putting other people first and presenting herself as a nice person. Her anger at the situation, added to thoughts of how 'compared with her', her siblings had an easier life, fuelled her depression.

Even though social comparison can give us lots of problems, it's interesting that sometimes we don't compare ourselves with Mr or Ms Average or people who are

similar to ourselves. Jane, a mother of two who devoted herself to looking after her children, had a number of friends who went out to work even though they had children too. Jane thought, 'I'm not as competent as them because I don't go out to work, and I have to struggle just to keep the home going'. When I asked her if she had other friends with children who did not have outside employment, she agreed that most of her friends didn't. However, it was not them she compared herself with, but the few who did have jobs. Part of the reason for selecting people like this is that we slightly envy them; we want to be like them.

Sometimes when we compare ourselves unfavourably with others, we also think that other people will have the same judgement of us. Other people will see us as inferior or bad in some way – that we are not as good as other people (recall 'Mind reading' on page 207). This can be quite a major problem if we have to open our hearts and share our difficulties.

A young mother's comparison

Diane felt really depressed after the birth of her child. She found it difficult to feel 'affection' for her new baby. She thought that her reaction was different from that of all her friends and therefore there was something wrong with her to feel this way. She was angry and frightened about her depressed feelings and envied what she saw as her friends being happy mothers. As a result, she never told anyone but suffered in silence, feeling different from them and cut off. Had she opened up to others (rather than feeling shamed by her comparisons) she would have found that these are sadly not uncommon experiences, and are no fault of her own – hormonal readjustment can be really unpleasant and play havoc with our minds.

One of the big benefits in working in group therapy is the degree to which people are prepared to share their problems. Often when one person is brave enough to own up to certain types of negative feelings or experiences, other people feel able to share. Indeed, sharing is much easier when we no longer compare ourselves unfavourably with others but realize we are all in this same boat of living in a world of suffering and hardship.

Even those with status can feel inferior

Social comparison is one reason why people who seem to have quite prestigious positions in society can become depressed. I worked with a doctor who had done well during his training yet, when he qualified, found the work stressful. He thought that he was doing much worse than his colleagues. Compared with them, he did not feel confident or on a par. As a caring GP he took more time with his patients and then struggled to keep up – but then blamed himself.

Balancing social comparison

Although it can be very difficult to avoid making social comparisons, here are some ideas to think through to help you think about how social comparison works within you.

- **When you compare yourself with others, choose a target who is most like you.** In other words, avoid comparing yourself with those who are clearly a lot better in certain ways. If a

comparison turns out badly, consider the reasons and evidence why this comparison may not be an appropriate one for you. We have different genes, backgrounds, talents and abilities – it is not a level playing field.

- **Think about the reasons for your comparison.** Although comparing ourselves with others is very natural, recognize that it can be harmful and keep in mind why you want to do it – what's the point of it for you? If it has value, such as giving you something you can try to copy, or it inspires you, that's fine, but if it depresses you – not fine.
- **If you do compare and feel down, avoid attacking yourself.** Try to remember that there are always people who are better at doing certain things or have more, but it does not make you a failure or inadequate because you can't do these things or don't have as much.
- **Think of your life as your own unique journey, with its own unique ups and downs and challenges.** Although you might want to live the life of someone else, this is not possible. Focus on you as yourself rather than you as compared with others.
- **If you are depressed, avoid labelling yourself as inadequate because you think others don't get depressed.** Sadly, many people do get depressed and anxious.
- **Spend some time refocusing and thinking about how social comparison can be hurtful for so many of us.** It is understandable, but think of ways of dealing with it that are kind to yourself.

Self-blame can come from fear

Self-blame and criticism are strongly linked to depression. When people self-blame and self-condemn, there is often a sense of the fear (e.g., of being rejected for mistakes or for not being good enough) and loss. Sometimes we learn to self-blame because we are frightened. Consider this on a world scale. Over thousands of years humans have been very frightened about what life can throw at them. Their children can die of numerous diseases, there can be famines and droughts and all kinds of unpleasant things. In societies throughout the world humans often imagine and then appeal to various gods who might be able to control bad things. Then they have to get them on side and they usually do this by sacrificing, appeasing or promising obedience to the chosen god. Problems arise if this does not work. The following year the diseases still come and so do the droughts, famines and other bad things. People rarely give up on their god as a poor bet; more commonly they blame themselves. They feel they must have done something wrong, or not done things sufficiently right, and have caused offence or displeasure to the god. Self-monitoring one's behavior, to check if it is acceptable – and then self-blaming if one thinks it is not – are common if we grow in fear of others. Sometimes in these societies if the gods do not help out there is a blaming of other people, 'Maybe it was those people who broke the traditions and caused the gods to abandon us' – and so starts a round of persecution born out of fear.

When we believe that powerful others and people can help, love or hurt us – and when we're children it is parents and teachers who can indeed do those things – it is natural for us to monitor ourselves, trying not to make them angry with us or to withdraw support and affection. Because we are monitoring ourselves, if things go wrong, we blame ourselves. If parents are in a bad mood, we might wonder what we have done to upset them. Thus a natural style of self-monitoring and self-blaming can become a style we carry through life. It is useful to remember that a style we learned out of fear – wanting to please and blaming ourselves, wanting to be loved or protected and not harmed – can become a style we use in all kinds of situations. We may never have learned to see the origins of our self-blaming style as being rooted in

fear and wanting love.

If you tend to blame yourself, often worrying if you've upset people, not done well enough or have various faults – always try to think about what you are really frightened of. Next, write down the reasons why these might be linked to your fears (of rejection, or people becoming angry). You might not be fully conscious of them at first. Consider if these styles have been picked up in childhood. If so, with your compassionate self-focus, consider the possibility that you are blaming yourself not because you really are to blame, but because it feels *safer* to self-blame and to protect yourself – just like the people who blame themselves if their gods don't come through for them. If it is about fear, safety and protection, then be honest about this, rather than thinking your self-blame reflects any truth about you!

Taking too much responsibility

Blaming occurs when we look for the reasons or causes of things – why did such and such a thing happen? When we are depressed, we often feel a great sense of responsibility for negative events and so blame ourselves. As noted above, the reasons for this are complex. Sometimes we self-blame because as children we were taught to. Whenever things went wrong in the family, we tended to get the blame. Even young children who are sexually abused can be told that they are to blame for it – which, of course, is absurd. Sadly, adults who are looking for someone to blame can simply pick on those least able to defend themselves.

Sylvia was a harsh self-blamer. Her mother had frequently blamed her for 'making her life a constant misery'. Her mother was herself a depressed and angry person, but Sylvia accepted her mother's explanations at face value – as children do. Not surprising, then, Sylvia took this style of thinking into adulthood and tended to blame herself whenever other people close to her had difficulties. Yet when Sylvia looked at the evidence, she realized that her mother's life was unhappy for a number of reasons, including a difficult marriage and money worries. As a child Sylvia could not see this wider perspective, but believed what her mother told her. Sylvia had to learn that her self-blame was a style she had picked up in childhood, and practise a more balanced approach. Sometimes, of course, this is quite frightening because it raises a number of other issues about the kind of person she is and the anger she might now feel.

When people are depressed, their self-blaming can become extreme. When bad things happen or conflicts arise, they may see them as completely their fault. This is called *personalization* – the tendency to assume responsibility for things that are either not our fault or only partly so. However, most life events are a combination of various circumstances. When we are depressed, it is often helpful to stand back and think of as many reasons as possible about why something happened the way it did. We can learn to consider alternative explanations rather than just blame ourselves.

The responsibility circle

Many of the things that happen to us are due to many reasons. Here is an example to help you think about this. Sheila's husband had an affair, for which she blamed herself. Her thinking was: 'If I had been more attentive, he would not have had an

affair. If I had been more sexually alluring, he would not have had an affair. If I had been more interesting as a person and less focused on the children, he would not have had an affair.' All her thoughts were focused on herself. However, she could have had alternative thoughts. For example, she could have thought: 'He could have taken more responsibility for the children, then I wouldn't have felt so overloaded. He could have spent more time at home. If he had been more attentive in his lovemaking, I might have felt more sexually inclined. Even if he felt attracted to another woman, he did not have to act on it. The other woman could have realized he was married and not encouraged him.'

One can then write down these various alternatives side by side and rate them in terms of *percentage of truth*. Or one might draw a circle and for each reason allocate a slice of the circle. The size of each slice represents the percentage of truth. In Figure 13.1 you can see how this worked for Sheila. The two circles represent a depressed view and a more balanced view. Note how some situations often have many causes. Sheila's more balanced, 'alternative view' circle seemed more true to her once she had considered it.

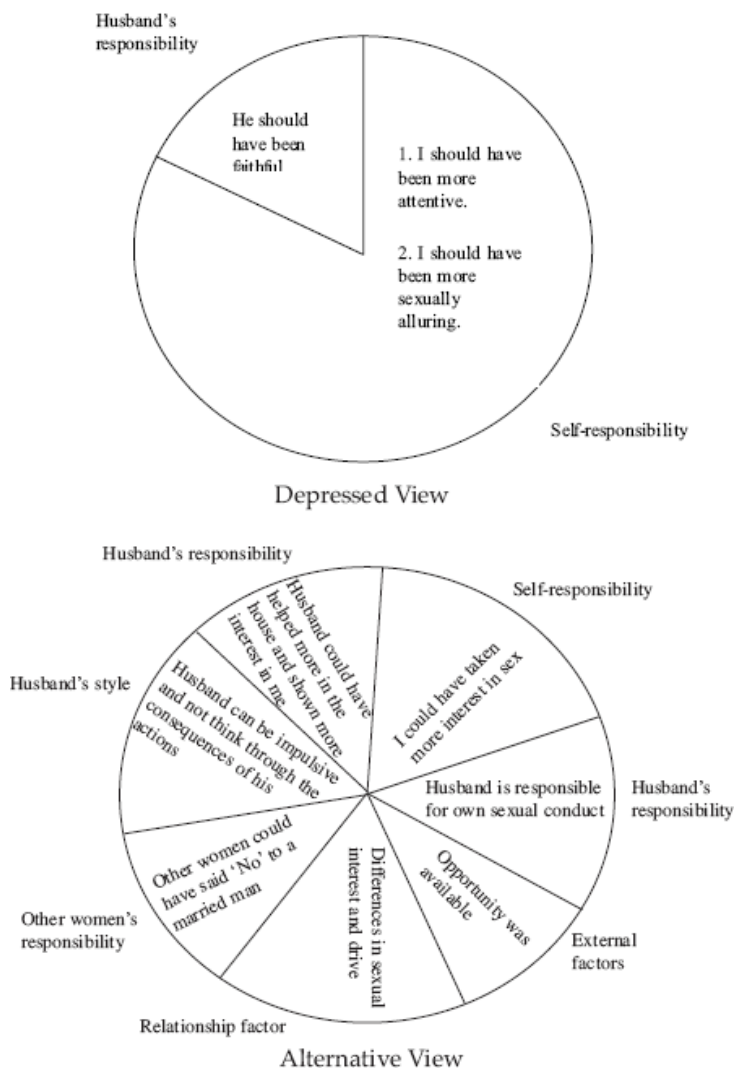


Figure 13.1 'Responsibility circles'.

The next thing to do is to go around the circle carefully and think about it in as compassionate, warm, kind and understanding a way as you can. Try and create those feelings in your mind as you consider the alternatives.

Think about the fact that if we take too much responsibility on our own shoulders then we are *robbing* other people of theirs. In parent-child relationships this can be very important. If parents feel guilt and blame themselves for their children's difficult or bad behavior, how are the children ever going to learn to take responsibility?

Tess had been depressed when her son Sam was born. Later on, she always blamed this for Sam's difficult behavior. The family therapist spotted this and noted that Sam had few boundaries because Tess always blamed herself for his behavior.

She could not confront Sam and help him become responsible for himself and his behavior.

Compassionate behavior is about giving people what they need, not necessarily what they want. When it comes to responsibility, don't be greedy and claim more than your fair share!

The same principle can apply when we blame others. We may simply blame them without considering the complexity of the issue, and label them as bad, weak and so forth.

Self-blame and control

One reason we might self-blame is that, paradoxically, it might offer hope. For example, if a certain event is our fault, we have a chance of changing things in the future. We have (potential) control over it and so don't have to face the possibility that, maybe, we actually don't have much control. In depression, it is sometimes important to exert more control over our lives, but it is also important to know our limits and what we cannot control. Sheila had to face the fact that she could not control her husband's sexual conduct. It was his responsibility, not hers. We have to be careful that, in self-blaming, we are not trying to give ourselves more control (and power) than we actually have (or had). We will look at this in regard to shame and abuse on pages 388–89.

Avoiding conflict and anger

Another reason for self-blame is that it may feel safer to blame ourselves than to blame others. By self-blaming we might avoid conflicts and expressing our own anger. You will need to be honest about this – how frightened of your anger are you? How much do you think it could turn you into an unlovable person? Remember the example above of the blaming ourselves if the gods don't help out or seem punitive (see pages 281–2) – sometimes we can be very frightened of anger and conflicts, and it is out of fear that we self-blame.

It may be that self-blame keeps the peace and stops us from having to challenge others. If, when we were children, our parents told us that they hit us because we were bad in some way, we might have accepted their view and rarely argued. This attitude can be carried on into adulthood. The other person always seems blameless, beyond rebuke.

People can be in conflict and in dilemmas about blame. One part of the self can feel angry, but another part can feel sorry or disloyal to (say) a parent. There can be a real desire to avoid conflict, and not wanting to be seen as ungrateful, aggressive or bad. The problem is, of course, that conflicts are part of life.

Sometimes we recognize that we are not totally blameless in something, but when it comes to arguing our case, the part that is our responsibility gets blown up out of proportion. We become over-focused on it and feel that we have not got a leg to stand on. However, most things in life have many causes, and the idea here is to avoid all-or-nothing thinking. By all means, accept your share of responsibility – none of us is an angel – but don't overdo it. Healing comes from forgiving yourself and others.

Expecting punishment

When bad things happen, depressed people sometimes feel that they are being punished for being bad in some way. It is as if we believe that good things will only happen if we are good and only bad things will happen if we are bad. If bad things happen, this must be because we have been bad, or simply are bad. When Kate lost a child to sudden infant death syndrome, she felt that God was punishing her for having had an abortion some years earlier. But millions of women have abortions and don't suffer this event, and vast numbers who suffer this sad event have not had abortions.

In depression the sense of being punished can be quite strong, and quite often, if this is explored, it turns out to relate to a person's own shame about something in the past. For instance, Richard's parents had given him strong messages that masturbation was bad. When he began doing it when he was twelve, he enjoyed it but also felt terribly ashamed. For many years, he carried the belief that he was bad for enjoying masturbating and sooner or later he was going to be punished for it. When bad things happened to him, he would feel that these were 'part of his punishment'.

To come to terms with these feelings we usually have to admit to the things we feel shame about and then learn how to forgive ourselves for them. It can be difficult to come to terms with the fact that the principles of 'justice' and 'punishment' are human creations. There is no justice in people starving to death from droughts in Africa. Good and bad things can happen to people whether they behave well or badly.

The fear of punishment can also come when we have had parents who frequently lost their temper and became very aggressive. Abigail's mother could be loving but at times would have rages and be physically aggressive. Clearly, those events created intense fear in Abigail. It is quite understandable that if there were conflicts or things went wrong, Abigail's threat-protection system would spring into action and she'd have an internal fear that something very bad or threatening was going to happen.

Expectations of punishment can operate at an emotional or gut level. It is important to stand back from that and realize what's happening inside. We can then practise our soothing rhythm breathing (see pages 123–4), and recognize that our feelings make sense, but we can allow ourselves to be gentle with them now.

Note that Abigail had the classic problem of wanting love from a person who could also be dangerous. This is very tough, because different parts of her brain are in conflict. The part that wants to be close to a loving mother and yearns for protection pulls her forward while the threat self-protection system pushes her away. These are difficult and confusing feelings to have to deal with and can really scramble our minds. If Abigail gets close to people this might reactivate her fear that people she's close to can blow up at her.

Some people can fear the punishment of Hell. But here's how I see it. If you believe in Heaven then it's kind and loving people who go there, right? And these are people who do not like others to suffer. So Heaven is full of those who would work to stop the suffering of others – so if Heaven is full of such souls, who could rest knowing people suffer in Hell – so how can Hell exist? For me it is our own minds that create these fears.

Self-criticism

Some people believe that self-criticism is the only way to make them do things. For example, a person might say, 'If I didn't kick myself, I'd never do anything.' Or they might believe that unless they are critical and keep themselves on their toes they will become arrogant, selfish and lazy. They use their self-bullying part to drive them on – sometimes in rather sadomasochistic ways. Such a person may believe that threats and punishments are the best ways to get things done. In some cases, this view goes back to childhood. Parents may have said things like, 'If I didn't always get on at you, you wouldn't do anything', or 'Punishment is the only thing that works with you'. They may also have been poor at paying attention to good conduct and praising it, and rather more attentive to bad conduct and quick to punish. As a result, the child becomes good at self-criticism and self-punishment but poor at self-rewarding and valuing. See Table 13.1 for ways to look at this differently.

In depression, however, self-criticism can get out of hand. The internal bully/critic becomes so forceful that we can feel totally beaten down by it. Then, when we are disappointed about things or find out that our conduct has fallen short of our ideal in some way, we can become angry and frustrated and launch savage attacks on ourselves. Research has shown that it is the emotions of anger and contempt in the attacks, not just the kind of things you think or say to yourself, that really do the damage in self-attack.⁵

It-me

The late Albert Ellis pointed out that self-criticism can lead to an 'it-me problem': 'I only accept *me* if I do *it* well.' The 'it' can be anything you happen to judge as important. For example, if you are a student, the 'it' may be passing exams. You might feel good and content with yourself if you pass or do well, but become critical and unpleasant with yourself if you do less well. Your feeling of disappointment fuels negative feelings of yourself. Or the 'it' might be coping with housework or a job: 'I only feel a good and worthwhile *person* if I do these *things* well.' Success leads to self-acceptance, but failure leads to self-dislike and self-attacking. Not only may you feel like this, but you might have beliefs where you think it's true: 'I'm not worthwhile if I can't succeed at things'.

This kind of thinking means: 'I am only as good as my last performance'. But how much does success or failure actually change us? Do you really become good (as a person) if you succeed and become bad (as a person) if you fail? Whether we succeed or fail, we have not gained or lost any brain cells; we have not grown an extra arm; our hair, eyes and taste in music have not changed. The consciousness that is the essence of our being has not changed. It is like water that can carry good or bad things but the water itself is not those things. Of course, we may lose things that have importance to us if we fail. We may feel terribly disappointed or grieve for what is lost and what we can't have. But the point is that these things will be more difficult to cope with if our disappointment becomes an attack on ourselves and we label ourselves rather than our actions as disappointing. It is very helpful to pull back and reflect on feelings of disappointment and consider if these feelings have somehow got linked to your feelings about yourself. If so, imagine your mind separating them and

saying clearly ‘I am upset about this or that – but this is not about me or the essence of me’.

Another key way to work on this ‘it-me’ problem is to separate *self*-rating and judgements from *behavior* rating and judgements. It may be true that your behavior falls short of what you would like, but this does not change the complexity and essence of you as a *person*. We can be disappointed in our behavior (and we can all do some daft, thoughtless and unhelpful things), but as human beings, we do not have to rate ourselves in such all-or-nothing terms as ‘good’ or ‘bad’, ‘worthwhile’ or ‘worthless’. If we do that, we are giving away our humanity and turning ourselves into objects with a market value. We are saying, ‘I can be treated like a car, soap powder or some other thing. If I perform well, I deserve to be valued. If I don’t perform well, I am worthless junk.’ But we are not things or objects. We are living, feeling, highly complex conscious beings, and to judge ourselves as if we are just objects carries great risks.

Self-attacking

Recent research has suggested it is our emotions and response to self-criticism that are associated with depression.⁵ Our research has also shown that people criticize themselves for different reasons. Sometimes it’s because they want to drive themselves to be better, but at other times it’s out of rage and hatred and just wanting to hurt themselves.⁶ We might make a mistake, have an argument with somebody, or eat too much and put on a few pounds, and realize that we could have behaved better. We might offer a mild rebuke to ourselves, or try to learn from things. However, when we attack ourselves there are emotions of frustration and anger and sometimes even contempt and shame. It is these feelings that we put into our self-criticism that turn it into much more of an attack on ourselves.

When self-criticism becomes *hostile* and activates basic beliefs about ourselves (of being weak, bad, inadequate, hopeless, and so on), then depression can take root. We all have a tendency to be self-critical, but when we become angry, frustrated and aggressive with ourselves and start bullying and labelling ourselves as worthless, bad or weak, we are more likely to slip deeper into depression. In a way, we become enemies to ourselves; we lose our capacity for inner compassion. It is as if the self becomes trapped in certain ways of feeling and then (because of emotional reasoning) over-identifies with these feelings. We think our feelings are true reflections of ourselves: ‘*I feel* stupid/worthless, therefore *I am* stupid/worthless.’

Here are some ideas about how to work with these difficulties:

- If I am honest, my self-criticism and attacking happens because I feel frightened about my mistakes or areas where I feel inferior. This fuels my frustration and anger with myself. Maybe I need to come to terms with what I am actually frightened about. (Spend some moments quietly reflecting on how your self-criticism links to your fears. What is the fear that underlies your criticism and anger with yourself?)
- How can I be compassionate to that fear?
- To sum up a person (e.g., myself) in simple terms of good/bad, worthwhile/worthless is all-or-nothing thinking. It is compassionate to appreciate that there are some things I can do quite well and some things I don’t do as well as I would like.
- All humans are fallible; we make mistakes, mess things up, behave selfishly – all we can do is

try our best to improve. Self-attacking does not really help me with this (see Table 13.1).

- Because I *feel* stupid and worthless does not make it true. I'm confusing a feeling with a sense of self.
- The idea of worth can be applied to objects such as cars or soap powder but not to people.
- I don't have to treat myself as an object, whose only value is what I achieve or do.
- If I say 'worthless', it is just one of a number of possible feelings that I, as a human being, can have about myself. I can try and put these critical feelings in perspective.
- I would not treat a friend like this – and anyway I am on the path of compassion, so that is what I am trying to develop step by step.
- If I had a chance to change the world I would not issue a command that everyone who fails should feel worthless – quite the opposite (a patient came up with this idea, which I think is very interesting and helpful).

Remember these thoughts and reflections have to pass the 'compassionate friend' test: Would you say this to a friend? Would you help a friend in this way? Would you agree that it is a kind and nurturing thing to think, say or do?

Self-hatred

As I have mentioned, it is the fear-linked and hostile emotions lurking in the self-criticism that often do the damage. Getting more insight into these emotions and some control over them can be very helpful. At the extreme, some depressions involve not only self-criticism and self-attack, but also self-hatred.⁸ This is not just a sense of disappointment in the self; the self is actually treated like a hated enemy. Whereas self-criticism often comes from disappointment and a desire to do better, self-hatred is not focused on the need to do better. It is focused on a desire to destroy and abolish.

Sometimes along with self-hatred are feelings of *self-disgust*. Disgust is an interesting feeling and usually involves the desire to get rid of or expel the thing we are disgusted by. In self-hatred, part of us may judge ourselves to be disgusting, bad or evil. When we have these feelings, there may be a strong desire to attack ourselves in quite a savage way – not just because we are disappointed and feel let down, but because we have really come to hate parts of ourselves.

Kate could become overpowered by feelings of anxiety and worthlessness. When things did not work out right, or she got into conflicts with others, she'd feel intense rage. Even while she was having these feelings, she was also having thoughts and feelings of intense hatred towards herself. Her internal bully was really sadistic. She had thoughts like: 'You're a pathetic creature, a whining, useless piece of shit.' Frequently the labels people use when they hate themselves are those that invite feelings of disgust (e.g., 'shit'). Kate had been sexually abused, and at times she hated her genitals and wanted to 'take a knife to them'. In extreme cases, self-hatred can lead to serious self-harming.

Kate's difficulties came to light in therapy, and for these types of extreme problem, therapy may be essential, but they are helpful to think about on your own too, because it is important to try to work out, and see if your bullying, self-critical side has become more than critical and has turned to self-dislike or self-hatred. Even though you may be disappointed in yourself and the state you are in, can you still maintain a reasonably friendly relationship with your inner self?

If your internal bully is getting out of hand, you may want to try the following: In

as warm and friendly a way as you can manage, say to yourself:

- I understand that my self-hatred is highly destructive – certainly not very compassionate.
- Am I a person who values hatred?
- If I don't value hatred and can see how destructive it is, maybe I can learn to heal this part of myself.
- I know perfectly well that, if I cared for someone, I would not treat them with hatred.
- Am I as bad as Hitler? No? Then maybe I need to get my hatred into perspective.
- Maybe I have learned to hate myself because of the way others have treated me. If I attack myself, I am only repeating what they did to me.
- I can learn to be gentle to my hatred – just be in compassionate self mode and then see how hate covers up hurt and fear. Gosh, that might be tough! But that is the compassionate path I'd like to take, even if it is small steps at a time.
- First, I commit myself to recognizing my self-hating part as understandable but unhelpful, linked to hurt – and then build on my desire to heal it.

We need to consider, too, that *we hate what hurts us or causes us pain*. Rather than focusing on hatred, it is useful to focus on what the pain and hurt is about. If you discover that there are elements of self-hatred in your depression, don't turn this insight into another attack.

The tough part in all this is that you will need to be absolutely honest with yourself and decide whether or not you want hatred to live in you. When you decide that you do not, you can train yourself to become its master rather than allowing it to master you. However, if you are secretly on the side of self-hatred and think it's reasonable and acceptable to hate yourself, this will be very difficult to do, and it will be hard to open yourself to gentleness and healing. For some people, this is a most soul-searching journey. But as one patient told me:

The hard part was realizing that, whatever had happened in the past and whatever rage and hatred I carried from those years, the key turning point had to be my decision that I had had enough of my hatred. Only then could I start to take the steps to find the way out.

And, of course, it is not just with depression that coming to terms with and conquering hatred can be helpful. Many of our problems of living together in the world today could be helped if we worked on this. We all have the potential to hate – there is nothing abnormal about it. The primary question is, how much will we feed our hatred?

Developing compassionate self-correction to replace harsh self-criticism

In this difficult and painful life, when we make mistakes, things don't work out, or we do things we deeply regret, learning to be kind to ourselves is the most important lesson to help us with depression. The first thing is to decide if you are actually frightened of giving up the self-criticism and self-bullying. If you ask people to imagine what life would be like if they gave up self-criticism and self-bullying altogether, they can actually be quite puzzled and even frightened. They may believe they would not achieve anything; would become lazy, arrogant or unkind. It's almost impossible for them to believe that they wouldn't become lazy because they have a

genuine wish to do well and a genuine wish to be kind.

The first thing is to make a distinction between what I call *compassionate self-correction* and shame-focused self-criticism or self-bullying. They are outlined and contrasted in Table 13.1. Compassionate self-correction is based on being open-hearted and honest about our mistakes with a genuine wish to improve and learn from them. No one wakes up in the morning and thinks to themselves, ‘Oh, I think I will make a real cock-up of things today, just for the hell of it’. Most of us would like to do well, most of us would like to avoid mistakes, most of us would like to avoid being out of control with our temper. We need to recognize that our genuine wish is to improve. Self-criticism, on the other hand, comes from a fear- and anger-based place. It is concerned with punishment and is usually backward-looking, related to things we have done in the past. The problem is you cannot change a single moment of the past, you can only change the future.

To appreciate the differences between compassionate self-correction and shame-based self-attacking, imagine a child who is learning a new skill but is struggling and making mistakes. A critical teacher will focus on those mistakes, point out what the child is doing wrong, appear slightly irritated, imply that the child is not concentrating or could do better if they try. The focus of that style of teaching is based on fear and shame – to make a child frightened or to feel bad if they don’t do well. In contrast, consider a kind teacher who focuses on what a child does well and shows them how they can improve and learn from mistakes, and genuinely takes pleasure in the child’s learning. Which technique do you think will help the child the most? Which one would you prefer?

If you do things wrong or make mistakes there is going to be regret, and momentary flashes of irritation, anger and perhaps calling yourself names. The point is though, how long do you stay here? How quickly can you switch to a compassionate refocusing?

TABLE 13.1 DISTINGUISHING COMPASSIONATE SELF-CORRECTION FROM SHAME-BASED SELF-ATTACKING

Shame-based self-attacking	Compassionate self-correction
Focuses on the desire to condemn and punish	Focuses on the desire to improve
Punishes past errors and is often backward-looking	Emphasizes growth and enhancement
Is given with anger, frustration contempt, disappointment	Is forward-looking
Concentrates on deficits and fear of exposure	Is given with encouragement, support, kindness
Focuses on a 'global' sense of self	Builds on positives (e.g. seeing what you did well and then considering learning points)
Includes a high fear of failure	Focuses on attributes and specific qualities of self
Increases chances of avoidance and withdrawal	Emphasizes hope for success Increases the chances of engaging with difficult things
Consider example of critical teacher with child who is struggling:	Consider example of encouraging, supportive teacher with child who is struggling:

Overview

The way we treat ourselves is quite complex, but the basic question is, can we be a friend to ourselves when things go wrong and we mess up? It is easy to criticize – critics are ten a penny. Compassionate self support is harder but well worth working for. One patient reflected on her depression and eventually recognized that her depression was strongly linked to her self-condemnation. ‘I condemned myself into depression,’ she said. ‘That was all that was in my head, but now there are compassionate alternatives and different feelings about myself.’

KEY POINTS

- We can attack ourselves without really realizing what we are doing. Our feelings and moods seem to carry us along into certain styles of thinking and evaluating ourselves.
- If we are to climb out of depression, we may have to take a good look at ourselves and decide to deal with and heal our self-criticisms, anger and self-hatred.
- The hard part can be helping ourselves to focus on the need for inner healing. Once we have done that, we can then start to focus on what we need to do to be healed. Often the first step is to sort out our relationships with ourselves.

EXERCISES

Exercise 1

The first steps are to use our rational and cognitive approach to examine self-criticism. The next exercises will use a more compassion-focused approach to work with our inner self-critic. So we can begin:

- Consider whether you have an underlying sense of inferiority, with a sense of being not quite up to it compared to others. (To be honest, many people do have that lurking sense and it's when it gets out of

hand that it becomes really problematic.)

- Think about whether this is because you have a sense of disappointment, and if related to disappointment is it a sense of fear of, say, rejection or being left behind?
- If so, when something happens and you feel bad about yourself, ask yourself: 'What am I saying about myself? What does this mean about me?' Write down these thoughts. Try to clarify the key streams of thinking:
 - what you think others might be thinking about you
 - what you are thinking about yourself.

Look at those thoughts and then:

- Consider in what ways you might be using: all-or-nothing thinking, emotional reasoning, disbelieving positives (see Chapter 10).
- Using your 'thought form', focus on the fourth column (see Appendix 1). Use your rational/compassionate mind to generate alternative views about yourself.
- Consider how you might help someone like yourself deal with self-attacking and bullying themselves, and then apply this to yourself. Learn to be gentle with yourself.
- Imagine a really caring person advising you. What would they say? Look at the evidence and think of alternatives. Ask yourself: How am I looking after myself with these thoughts/feelings? Do my thoughts help me to care for or look after myself? In this way, slowly build up your insights.

Exercise 2

You probably have a sense of the kind of things you say and feel about yourself when you are in that frustrated or disappointed self-critical state. You know what your inner critic says and the kind of attacks it launches. It might have grown from childhood or even started as someone else's criticism of you. We are now going to work with this inner self-criticism and bullying in a different way, first using our compassionate image.

- Set some time aside and then sit or lie comfortably and engage in your soothing rhythm breathing. Create your compassionate self inside of you (see pages 149–51). Imagine that you have all of the ideal qualities of kindness, wisdom (you know how difficult our evolved brains are), strength and maturity, and are never condemning. It is you at your best and how you would most like to be. Spend some minutes really focusing on those, remember to adopt a compassionate facial expression and if possible a relaxed body. Feel yourself expanding as if you are becoming powerful in a calm, confident and very benevolent way. When you feel some degree of contact with those feelings you can try this exercise. Imagine your self-critical side as a person, as if you could take it out of your head and look at it. Now, in front of you, imagine yourself being critical to yourself. See the facial expressions and look at the emotions that self-critical part of you directs at yourself. Now see beyond those emotions, to the disappointment or the fear. Extend your compassion to your critical self. You're not arguing or trying to change the critical self, and it doesn't matter how your critical self wants to respond, even by devaluing what you're doing or ridiculing it. Continue to feel compassion for it and watch what happens. Offer it as much compassion as it needs. One patient told me her self-critical side lifted two fingers to the compassionate self, with words to go with the gesture, but she stayed in compassion mode and gradually the self-critic 'got smaller and then seemed rather sad, really'.
- A variation on this can be to engage in your soothing rhythm breathing and then imagine your compassionate image (see page 156) standing next to you and then both of you extend compassion to your critical self. Again, note what happens. If feelings emerge, be mindful of those feelings and stay with them.
- A third exercise involves writing a compassionate letter to one's self-critical side or inner bully. The letter might look like this:

Dear inner critic,

I know that you get frustrated and upset and become angry with me. This is because you are frightened of what will happen if we don't succeed/achieve/change etc. Actually, like me, you want to be respected, loved, cared for or admired – the basic human wants. The thing is, you worry that all these things will slip through your fingers unless we get our act together. Look, I understand your fear. I also understand that your response is to panic and lash out like this. I'm very sorry you feel so vulnerable. It's not your fault but this attacking actually contributes to our feelings of vulnerability and depression, and so it's time to learn how to be gentle and kind in these situations. We can learn to do the things that will genuinely move us forward in life. In your heart you know this. So I'm not going to attend to the things you say as much as I used to, okay? I used to get caught up in them and believe that these thoughts had some truth to them, but they don't really – it's just that we're frightened of rejection. But if I am honest and compassionate I can learn how to cope with rejection if it comes.

Writing these letters can help you develop a different attitude to your self-critic, and become more

aware of when that part of you – linked to your feelings of anger, frustration and fear – kicks in. That then becomes the signal to switch to your soothing breathing rhythm and compassionate-balanced focusing.

As with all these exercises, go one step at a time and only engage in things that you find helpful to you, and can see the point of. One of the key elements of helping ourselves is to work out what is helpful to us, because what might be helpful to me may not be helpful to you and vice versa.

In this case imagine your inner critic, and then from your compassionate self recognize that you do not need to keep this 'voice from the past'. It was not there to really help you. So now imagine that you are leaving it and see it gradually move away and grow smaller, smaller, smaller. You are creating in your mind 'letting-go conditions'. If this is too difficult and you think it could be a major source for your depression, then maybe professional help would be useful for you.

Sometimes the voice of the critic might remind you of someone who was unkind or even abusive to you. Here you might need a more assertive response. Remember, compassion is not submissive or weak. Finding what works for you can be key here.

Depressed ways of experiencing ourselves: How compassionate re-focusing can change our experience

The last chapter focused on thoughts and feelings against the self. This chapter explores how we label ourselves and think and feel about ourselves in unkind ways. Learning to spot and counter these ways of experiencing ourselves can help with depression.

Self-labelling and the different types of self

Most of us have had the experience of feeling bad, inadequate and useless at times. These feelings usually arise when we are disappointed by our actions, have failed at something or have been criticized by others. As we grow up, our parents, teachers, siblings and peers *label* us in various ways and may call us things that are hurtful. We may be told that we are a nuisance, bad, unlovable, stupid. Or perhaps overprotective parents say that we are not able to make our own decisions or cannot cope by ourselves. Over time, we develop various ways of thinking about ourselves as being a certain kind of person – that is, we come to *label and describe ourselves in various ways*. Now the label can colour the experience.

We can often label and experience ourselves differently in different roles. For example, suppose you write to a pen friend – how would you describe yourself? Suppose you are applying for a job – how would you describe yourself? If you are writing to a dating agency, how would you describe yourself? Finally, if you are writing to a priest or someone similar to confess something and seek forgiveness, how would you describe yourself then? The chances are that each letter would say different things about you, because we humans are very complex and have many different qualities and parts. In fact many psychologists suggest we have many *different types of self and potential selves within us*. We can play different roles with different people. With some people we might be light and humorous, but with others we might feel irritable and tense, and with others again we have a sense of unease or anxiety around them. And of course different situations seem to draw out or activate different aspects of ourselves. I am happy to talk to an audience about my specialist field, but put me in a car and tell me to drive to London and you'll fill me full of dread and anxiety.

When we become depressed, the richness, variety and vitality of our many and potential selves drain away and we start thinking of ourselves in rather simple terms,

or labels. The labels might be triggered by life events. For instance, you might be rejected by someone you love and then label yourself as unlovable. Or you might fail at some important task and then label yourself as a failure. Negative *labels* are often sparked off by negative *feelings*, which in turn may be strong echoes from the past.

Self-labelling is essentially a form of name-calling. In depression, we come to experience ourselves as if that label (e.g., weak, inadequate, worthless, bad) sums up the whole truth about us. It can feel *as if we are* the label: our whole self becomes identified with the label. The judgements, labels and feelings that we have about ourselves when we are depressed tend to be the same the world over. Whether we live in China, the United States or Europe, depression often speaks with the same voice. Here are some of the words depressed people typically use to describe themselves:

bad
empty
failure
fake
hopeless
inadequate
incompetent
inferior
loser
nuisance
outsider
rejectable
small
ugly
unattractive
unlovable
useless
victim
weak
worthless

Consider for a moment a person you care about. How do you think they would feel if you started to call them these names? Whenever they made a mistake, you called them incompetent or a failure. Of course, it would make them pretty miserable or they'd sack you as a friend. It is no different from your own self-treatment, though. It is easily done but very unhelpful. The trick is to learn to be kind and balanced in our relationships with ourselves when the going gets tough, when we fall over, when we make mistakes, when we are rejected.

However, *we can train our minds* to realize that the feeling and label of being 'worthless or useless' is only one of many possible sets of judgements. There are others, such as: honest, hard-working, carer, helper, lover, old, young, lover of rock music and chocolate, gardener. Our depressed negative judgements, which seem so certain and 'all or nothing', can also be examined for their accuracy and helpfulness. Although depression tends to push us towards certain types of extreme judgements, it is helpful to think that these are only parts of ourselves. Like a piano, we can have and play different notes and can play them in different combinations. We are far more complex than our depression would have us believe. Consider the typical kinds of labels you put on yourself and then reflect on the following:

- As a human being, I am a complex person. I am the product of many millions of years of evolution, with an immensely complex genetic code and billions of brain cells in my head. I am also the product of many years of development, with a personal history. One of the things evolution has given to all of us is the ability to operate in **many** different states of mind and in different roles. Therefore to judge my whole self, my being and my essence, in a single negative term is taking all-or-nothing thinking to extremes.
- When I am depressed, it is natural and understandable that I tend to **feel** bad and inadequate, but this does not **make me** bad or inadequate. To believe it does would be a form of emotional reasoning. I might feel worthless (that is what depression does to feelings) but this does not make it true. These are the thoughts linked to my fears and anxieties and frustrations but they are not truths.
- Although I tend to focus on negative labels when I am depressed, I can try to balance these out with other ideas about myself. For example, I can reflect that I am honest, hard-working and caring – at least sometimes. I can consider alternative labels and inner experiences. When depressed it is easy to focus on the negatives, because that's what depression does. The trick is to refocus my attention on the things that I appreciate about myself, even if they are difficult to see at times. The act of practising helps me take control of my mind rather than letting depression determine what I think and feel.
- How do I see myself when I'm not depressed? Okay, maybe not as good a person as I might like, but certainly not as I do now.
- Although depression likes simplistic answers to complex problems and tends to see things in black and white, good and bad, I don't have to accept this view but can try considering the alternatives.
- The essence of me is really my conscious self. Conscious -ness is like a spotlight that can shine on many things. It can cast shadows, the light is not the things it lights up – just like me! (See page 121.)

So our labels reflect inner feelings and the way others have labelled us, but we must be careful not to think that the feeling captures the self. The feeling is not yourself – it is (just) a feeling in your consciousness (about yourself) that you are having in this moment. Let's look at some typical examples that operate in depression.

The empty self

Some depressed people can see themselves as *empty*. Depression tends to knock out many of our positive emotions, and it is not uncommon to find that people lose feelings of affection for those around them. Hence they feel emotionally dead, drained and exhausted. As one patient told me, 'I am just an empty shell'. This is an example of allowing our feelings to dictate our thoughts. The *feeling* of being empty and alone is not the same as actually *being* an empty shell.

When dealing with these distressing feelings it can be helpful to recognize that they can be a natural symptom of depression. Depression can knock out our capacity to feel. Thus, it is not you, as a person, who *cannot feel*; rather, you are *in a mental state of not feeling*. As soon as your mood lifts, you will feel again. Try not to attack yourself for your loss of feelings, even though it can be desperately sad and disappointing (see page 411). Indeed, if you focus on the sadness of it, rather than the badness, you might find that you want to cry, and crying might be the first glimmerings of a return of feelings. If this happens, put time aside to allow yourself to cry, check out if you have fears of crying and think about what they are. Think about how you may address those fears. Consider how in the past you have coped

with these feelings, and you may have more courage than you are acknowledging.

Sometimes the experience of emptiness is linked not to negative things about the person but to the absence of positive things. Paula explained this feeling to me: 'I've never felt bad about myself really. I think I'm not a bad person on the whole, but I just feel that I'm a "wallpaper person".' She felt neither lovable nor unlovable; she just didn't feel anything strongly about herself one way or another. She revealed a history of emotional neglect by her parents. They had not been unkind to her in an aggressive way but were simply not interested in her. With no one in her life who she felt valued her, Paula had been left with feelings of emptiness and drifting through life. When she looked at the advantages and disadvantages of this idea of being a "wallpaper person", she discovered that, although it gave her a feeling of emptiness, it was also serving a useful purpose: *it protected her from taking any risks*. She had a motto: 'nothing ventured, nothing lost'.

This view of the self was also a safety strategy protecting Paula from the fears of going out into the world to try to achieve things and change her sense of herself. Changing things we feel safe and familiar with can be difficult and frightening – even if those things are not good for us.

One way to approach this is not to think of getting rid of anything. We can keep our old beliefs as long as we like, if we feel safe with them, but we can also try to build new ways of thinking and feeling and gradually see if we like those better as they become safe and familiar. Feel free to hang on to your beliefs as long as you feel you need them. Try not to feel that something is going to be taken away from you, leaving you vulnerable. But also allow yourself to *outgrow your old beliefs*.

Here are some ideas for building new self-experiences:

- Compassionately prepare yourself to take risks and learn how to cope with failure, disappointment and possible rejection (see Chapter 22). This will be much easier if you learn the art of being kind to yourself in the face of setbacks. We can start with small steps.
- Focus on times when you do have some feelings for things – maybe the music you enjoy, or watching a movie.
- Develop your mindful attention (Chapter 7) and note how your mind pulls your thoughts this way and that – so, far from empty.
- Consider that emptiness is a form of emotional reasoning, such as 'I feel empty therefore I am,' which, of course, does not make it true (see pages 213–15).
- Consider that what you are calling emptiness might actually be loneliness or a kind of lossiness – unsure what you want to do or where to go in life. If so, be honest about that and gently accept it, but also see it as a specific problem to be worked with.
- Engage in your compassionate self work and imagery (see Chapter 8). Sometimes working to help others – making that a life goal – can give us a new sense of purpose.

As we have seen, a key step forward is to act against the feeling or thought that seems to be causing us trouble. Let's think why you are not empty. Consider your fantasies, dreams, desires and preferences. The pattern of your preferences makes you a unique person. For a start, you probably want to feel different from how you do now. That must mean that you desire to achieve a certain state of mind – not to be depressed any more.

Let's begin by looking at your preferences. What kinds of films do you prefer and what kinds do you tend to avoid? What kind of music do you like and what leaves you cold? What kind of food do you like and what makes you feel sick? Would you prefer to eat a freshly baked potato or a raw snake or a cockroach? Simple and silly

ideas perhaps, but you do have preferences. What kinds of people do you like and feel comfortable with? Which season do you like best? What kinds of clothes do you prefer? If you say that you have no preferences, try wearing a salmon pink top with fluorescent green trousers that don't fit! The point is not so much that you are empty but that you may, for example, lack confidence to do the things you want, or be feeling very tired, or feel trapped in a lifestyle that is boring. You see, the label does not help you — but working out the actual problem might.

Think about what could happen if you started working on your preferences and developing them. This means not only thinking about your preferences but also acting on them, so it might lead to some anxiety. If so, write down your anxious thoughts and compassionately think how to shift them — see if your fears are exaggerated. How could you take steps to overcome your anxieties?

Suppose you admit that, however mild they might be, you do have preferences, and emptiness is in your feelings not fact. But then you might say, 'Yes, but I don't have any qualities *that another person might find attractive*.' That's another issue — that's not about you, but how you relate to other people. If this is what you think, then your feelings of emptiness may possibly be more related to loneliness. Or perhaps it's a problem of confidence. Have you shared your preferences with others? If not, what stops you? What would it take for you to turn to someone you know and say, 'I'd like to do this or that. Would you?' If you find that you have thoughts of, 'But they may not want to, or they might think that I was being silly or too demanding,' the problem is less one of emptiness and more one of confidence. It may be true you have a problem with confidence, and it's also true that if you do not practise expressing your preferences and desires it can sometimes be difficult to know them yourself. How can you learn what you like and enjoy if you don't try things out and discover you like this but you don't like that?

It may also be that you are being unrealistic. Do you want to be attractive to some people, or to everyone you meet? Are you too focused on social comparison (see pages 276–81)? Do you believe that, because your parents didn't seem that interested in you, nobody will ever be?

Here are some more balanced, helpful ways of thinking about this:

- Telling myself I'm empty is a form of emotional reasoning.
- I can learn to focus on my preferences and start to share these with others. It may be difficult, so I'll go one step at a time, but at least I'm on the road to developing.
- I may be discounting the positives in my life and saying that some things about myself don't count. If so, what would they be?
- I might be self-labelling here and not appreciating that all human beings are highly complex.
- Maybe it is not so much that I am empty but that I am lonely and I have difficulties in reaching out to others.
- Maybe it is a problem with confidence. If I felt more confident in expressing myself, would I feel empty?
- Am I attacking myself by saying that nobody could be interested in me without giving them much of a chance? If so, how could I give them a chance?

Feeling a nuisance

Nearly all of us humans want the approval of others. This often means that we want

to be seen as having things (e.g., talents and abilities) to offer others, and it may be easier to care for others than to be cared for. One problem that can arise is that, when we have needs that can only be met by sharing our difficulties with other people, we feel that we are being a nuisance and may not deserve to be cared for (see Chapter 18). People can be riddled with guilt and shame about needing help. In their early life, their needs may not have been taken seriously. One patient of mine – whose motto was, ‘A problem shared is a problem doubled’ – was constantly monitoring the possibility that she was a burden to others. This led to guilt and feeling worse, which, of course, increased her need to be cared for and loved.

The fear of being a nuisance is a common one, but also a sad one. Of course we can feel like a nuisance in a whole variety of ways. Maybe we are physically unwell, are not as competent as others in the group and so on. Sometimes we may have difficulty in being fully open about our needs and asking others for help. Instead, we tend to ‘beat about the bush’ when it comes to our own needs and feelings, and send conflicting messages to others. People’s sex lives can be full of these kinds of worries in approaching one’s partner for a sexual encounter.

Sometimes patients come to therapy but feel awkward, and instead of getting down to the business of trying to sort out what they feel and why, they constantly worry about burdening me. They may feel they are not entitled to be in therapy, that their problems are not serious enough, that they are ‘making mountains out of molehills’. Rather than allow us to come to a view on this together, they’ve already decided that they’re being a nuisance to me. I explore this fear of being a nuisance quite early on. Sometimes it relates to shame, sometimes to a fear that I won’t be able to cope with their needs because these are too great and complex. At other times it relates to trust: they think that, while I will be nice to them on the surface, secretly I will be thinking that they are time-wasters, that I will deceive them about my true feelings.

Concerns of being a nuisance and being a burden can be upsetting, so it’s useful to consider the following points.

- All humans have a need for help from time to time.
- Am I labelling and criticizing myself for having these needs rather than facing up to them and understanding what they are?
- What does my compassionate/rational mind say about that?
- What is the evidence that other people won’t help me or want to share with me if I ask them?
- Am I predicting a rejection before it comes?
- Am I choosing to ask people for help who I know in advance are not very caring, or would have difficulty understanding my feelings?
- Am I saying that all my needs must be met before I can be helped and therefore thinking in all-or-nothing terms?
- Are some of my needs more important than others? Can I work on a few specific problems or needs at a time?
- Can I break my needs down into smaller ones, rather than feeling overwhelmed by such large ones?
- Can I learn to be more assertive and clear about my specific needs? Would that help me?

There is another aspect that can be useful to consider. Sometimes we know that we are in need of healing or help and that we have to reach out to others, but we don’t know what for or what exactly our needs are. That takes some thought, but if you do become clearer on these issues, *consider what you will do to help yourself if*

you do find someone who can meet some of your needs. This is quite an important question. Of course, you might feel happier with some of your needs having been met, but how will this change you? How will you use these met needs for personal growth? When we think about this we sometimes recognize that we are looking for other people to help us develop confidence, or help us feel better. In fact, although others can be very helpful in this regard, these are things we need to work on for ourselves as well.

Sharon was afraid to ask her husband to spend more time with her and to be more affectionate. She thought that this would interfere with his work and that she was simply being a nuisance to him. However, as she explored these needs and considered how she would be different if they were satisfied, she realized that she actually needed his support and approval to boost her own self-confidence. Then she would be more able to go and find a job. By thinking what she would do if some of her needs were met – that is, how this would change her – she recognized two things: first, that there were things she could do for herself to help boost her own confidence (such as not criticizing herself and learning to be more assertive); and second, she recognized that she could be clearer with her husband about the fact that she wanted him to help her gain confidence to go looking for work.

Sharon also realized that seeking more affection from her husband might not be a burden but would actually strengthen the relationship, and this was something she could test. On reflection, she saw that her husband might well benefit from talking more about his feelings and needs, too. She was able to see that her needs could be joint needs. When she spoke to her husband about this, at first he did not really understand. But she stuck to her guns, and later he, too, came to see that he had been so focused on work that he had become lonely himself and felt their relationship was drifting. Not knowing how to address that, he drifted further into work. Moreover, he admitted that he knew that Sharon had felt down but was not sure what to do because she only spoke about her feelings in a general way, not the problems that lay behind her feelings – how she was bored and lonely in the house and she wanted to get out and find a job. To not burden her when she felt down, he had stopped sharing his own problems with her. We can stop sharing for fear of burdening others! Relationships flourish precisely because we share our needs and grow together, not because we hide them.

Fakery

Related to emptiness but different from it is the feeling that one is a fake. From an evolutionary point of view, deception and fakery have been very important behaviors for animals and humans. Quite a lot of animal behavior actually depends on fakery and bluff. Faking and bluffing can be very protective. It is also important to note that children have to learn how to lie. The ability to lie and fake things is actually an important social skill. However, when we become depressed we can feel as if everything we've done has been a pretence or a fake, or simply the result of luck. Depressed people begin to devalue their previous or current successes. The reasons for this vary. Sometimes they are perfectionists and think less of things that they feel are not up to standard. They know that there are flaws in their actions or achievements, but become overly focused on them. They think that they were

pretending to be more competent. When a professor who held an exalted position in the academic world won a prestigious prize he became depressed, because he felt that he had fooled everyone and that all his writings were of little value. Success did not fit with this self-identity. There was also a fear that he might not maintain his reputation, people would find errors and it would collapse; people would then be very disappointed in him.

When depressed, we may also start to worry about whether the feelings we had for others in the past were genuine, or we were fooling ourselves. However, depression is the worst possible time to start making these kinds of decisions because it reduces the capacity for positive feelings, and we often become less affectionate. In addition, feeling that we are deceiving others can lead to guilt, which we then try to cover up (see Chapter 18).

When Brenda became depressed, she became preoccupied with having fooled Nick into marrying her and that she was now faking love for him. When she came to see me, we had a conversation that, boiled down to its essentials, went something like this:

Paul: *When you got married, did you think that you were faking your love for Nick?*

Brenda: *No, I wouldn't put it like that. I was, to be honest, more unsure about him and more worried than I let on, but we got on okay and I thought it would work.*

Paul: *Marriage can be a scary time, so maybe you had mixed feelings and were unsure of what to make of those feelings.*

Brenda: *Yeah, I guess so. It was a big step to get married and I was worried about whether I was making the right decision.*

Paul: *Do you think that being understandably worried about making the right decision means that you were being deceptive?*

Brenda: *I'm not sure.*

Paul: *Okay, well, let's put it this way. If you are being deceptive with Nick, is it possible that this is because you are confused in your mind and not sure what you really feel about him?*

Brenda: *Oh, yes, all my feelings seem confused right now.*

Paul: *Okay, well, let's see this problem as one of confusion rather than one of deliberate deception. Right now you may not feel a lot of love for Nick, but we aren't sure why that is. Maybe there are things you are resentful about, or maybe there are other reasons, but if we work through these, step by step, we might get a clearer picture of what you feel. The problem is, if you just attack yourself for feeling that you are deceiving Nick, then you will feel guilty and find it more difficult to sort out your feelings.*

This gradually made sense to Brenda. It turned out that, because she had not been passionately in love with Nick from the start, she felt in her heart that she had deceived him and this made her feel terribly guilty. To overcome her guilt, she would do things in the relationship that she did not want to do (e.g., sex, going out), but she also felt resentful for giving in. She felt rather used by Nick. Slowly Brenda began to see that her main feelings were actually anger and resentment. Once she stopped feeling guilty for having deceived Nick and faking love, she could move on to sort out the genuine problems in the relationship. To do this, she also had to recognize that love is complex and not at all like the movies make out. Brenda discounted the positive in her life by only focusing on her negative feelings and on the times she felt confused about her feelings for Nick rather than on the times she enjoyed being with him. Working on the resentment actually strengthened their relationship.

Sometimes people feel that they have no choice but to fake things. For instance,

they may feel that they have to fake love, to hold together a relationship or a family or, as in the following example, a career. Mike faked a liking for his boss who, he thought, could sack him if he did not make a good impression. He came to hate himself for being (as he saw it) weak. However, he could have looked at it differently. He could have said, 'I understand that I need to hold on to this job and I don't have that much power to do this other than creating a good impression and getting on with my boss. Actually, I am a very skilled social operator.' This is not to say that it's okay to fake – that's a personal decision. Rather, we need to be honest about it, understand the reasons for it and avoid attacking ourselves for it. If we want to reduce the degree to which we fake things with others, we need to learn how to be more self-confident, compassionate with ourselves and others, and assertive. That will be hard to do if we are attacking and running ourselves down.

The fear of being a fake is not only associated with guilt (as it was for Brenda) but carries the fear of shame (Chapter 17) and being found out. Some people live in constant fear that, because they are living a pretend life, they will be found out, ridiculed and shunned.

Here are some ways to think about dealing with feelings of being a fake:

- It may be true that I may have been lucky in some things, but this cannot account for everything I have achieved. I must have some talent, even if it is not as great as I would like.
- Sometimes I fake things because I am confused and/or frightened. It would be better to work on this confusion and fear rather than simply attack myself for the fakery and pretence.
- Faking or not faking is rarely all-or-nothing. There are degrees of faking and some are actually helpful.
- If, since I feel like a fake, I believe I am a fake, this is emotional reasoning. I could be more balanced in my thinking here.
- Feeling like a fake is often a symptom of depression. My depression may not be giving me an accurate view of things or myself.
- If faking is upsetting me, it would be better for me to understand my reasons for it. I might then be in a better position to change. If I attack myself for faking, I will feel much worse and need to fake more, not less. Let's be compassionate here and see what lies behind these feelings.

Fakery and deception are more commonly experienced in depression than is often recognized, and the question of fakery and deception often goes to the heart of many social dilemmas. We can feel intensely guilty when we know that we are not being fully honest and genuine. Or we can feel very vulnerable when we are not confident of our behavior or performance and think others might spot the flaws and regard us as fakes. The problem is that, in many situations, there is often no one genuine feeling but many different feelings. If you have a row with your partner today, this does not mean that all the other good times you had together were fake. If you are depressed, this does not mean that the other times when you felt good or achieved things were a pretence; it means that you can feel different things at different times and when in different states of mind.

Be honest with yourself

Self-honesty can be very difficult and in fact we may never actually achieve it because so much of what goes on in the mind is actually outside of our consciousness – this is not our fault of course! Nonetheless it is important to try, and this will

become easier once you learn self-kindness, to replace self-criticism and take balanced positions on things (avoiding black-and-white and either-or thinking). When it comes to expressing feelings and behaviors to others my main thought is whether it is helpful or destructive. Sometimes we are kind to others when we don't really feel like it, because we know that it is good for them or they will like us. Sometimes we have to learn more assertiveness or to become skilful social players, recognizing that at times hiding our feelings is actually a quite useful protective ability.

The key issue is not to be critical but to think what would help you to be more able to express your feelings if that's what you want to do, or accept that you may not be able to in certain contexts. For example, Karen carried a lot of anger towards her mother over various things in her childhood. Over a number of years she planned what she wanted to say and would sometimes ruminate on her anger, but when she saw her mother she was always kind and polite. Then her mother became very ill, and it was clear that Karen was never going to express her feelings. Developing compassion for the dilemma Karen had been in, giving up telling herself 'I should've told her earlier!', which also had some degree of self-anger, was helpful. Karen learned and developed compassionate acceptance, that she wasn't honest with her mother, but had chosen to protect her mother. Like all things in life there were advantages and disadvantages, and she could come to accept that. Indeed, Karen was able to think about her caring and polite side and her self-sacrifice in a positive light instead of an angry, self-critical light.

KEY POINTS

- We often experience ourselves as if we could be summed up in single words (weak, empty, inadequate, unlovable, fake, etc.).
- The labels may vary from person to person, but most of them imply a negative rather than a positive judgement of ourselves.
- When negative feelings and labels become central to the way we experience ourselves, they can influence much of what we feel and think (look back at page 28).
- It is helpful to recognize that these labels are often based on anger, frustration, disappointment, fear or loneliness, or may come from what other people have said to you and how they have labelled you.

EXERCISES

Exercise 1

Look at the labels that appeared listed on page 306 and see if you think that any of these apply to you. If not, maybe there are others that might apply. Examine whether you tend to sum yourself up in single words. Single words can't really describe your complex feelings and thoughts though, can they?

Exercise 2

Begin to use your compassionate/rational mind to generate alternatives to these single labels. For example:

- Label says: 'I am a failure'
- Compassionate/rational mind says _____ (create a compassionate expression as you read through below)

'This label comes from feeling depressed, and when I am depressed, I tend to think in a lot of negative ways. For example, I tend to discount the positives in my life and indulge in emotional reasoning. Sure, right now I feel bad – but let's not turn that bad feeling into an attack on the whole of me. Successes and failures come and go in one's life, but these are not the essence of a person. My feeling is more one of anger, frustration and disappointment and everyone's entitled to those feelings. I would not label my friends like this if they had setbacks and disappointments; I would be understanding of their feelings. Perhaps I need to learn to do that to myself as well. What evidence is there against this label? Am I being all-or-nothing here? If I was helping a friend in a similar situation, what would I say to them?'

Work out if this kind of compassionate reasoning is helpful to you. Be aware that you might tend to

undermine your efforts to switch into a more compassionate, gentle and balanced approach. Ask yourself, 'What have I got to lose by really focusing on these alternatives for a while and seeing if they help?' Remember, in depression we are usually very good at focusing on the negatives. Negative beliefs from childhood and stress hormones incline us to focus on the negative. The task now is to develop the ability to look for the positives. The more you practise attending to the positives, the better this will be for your mood and reducing stressful signals.

Exercise 3

When did you first start to think of yourself in this way? Is it the depression speaking, or was it other people who told you these things that labelled you? If it is others, then follow these steps.

- 1 Take a piece of paper and write down some times you can recall where others labelled you in a certain way, or by their actions gave you the impression of what they thought about you. Sadly people label other people all the time, and it's how we deal with it that's important.
- 2 Consider what might have been in the mind of the labellers or name -callers or people who judged you or criticized you. Did they have your best interests at heart? Really think about this now. Were they doing this from a position of genuine caring and concern about you? How did it benefit them to label you in this way? Did it stop them having to blame themselves? Were you simply an easy target? Were they people who tended to be somewhat bullying and easily frustrated in many other situations? In thinking about this then consider what is in it for you to buy into their views. Maybe you did at the time out of fear, confusion or the hope they would love you – but maybe these people are not reliable judges – and if we are truly honest you know that in your heart.

What we are trying to do here is to help you not to take these judgements at face value. This can be hard, because sometimes we feel we should accept the judgements of others, especially our parents. Not to do so can feel like a bit of a rebellion or even a betrayal – so you might have to have a go at this one a few times.

- 3 Sometimes it can help to imagine yourself having a conversation with your compassionate image and talking through these situations. Remember these are compassionate discussions, the kind of conversation you might have with someone in your situation who you really care about and who you want to see free of suffering. When engaged in this work, try to create kind, understanding feelings in yourself. You may then wish to think about whether the time has come to grow away from the labels that others have given you, to become your own person. Allow yourself to think of letting go these labels if you don't need or want them. What effort would that take? What would the advantages and disadvantages be? What would stop you doing this?
- 4 Here is an exercise that you will have read a few times now. Engage your soothing rhythm breathing and take up a relaxed posture. Create feelings of compassion within yourself, imagining yourself to be a mature, wise, caring, warm person who does not get flustered. Remind yourself of you 'at your best'. Adopt a kind facial expression and allow yourself to note that feeling. With that kind facial expression, imagine the part of you that labels you standing in front of you. Look at its facial expressions and the motives behind the labelling. Extend your compassion to it, see the fears behind the labelling. Whatever the labelling part of you says, whether it tries to ridicule you or put you down in some way, remember you are the compassionate side, the wise side, you've seen this all before and are not taken in by it. Continue to send your compassion to this part of you and see what happens. If you feel too drawn in to the labels, pull back and refocus on the compassionate self until that feels stable again – then repeat.
- 5 In the next part of the exercise we will do exactly the same except this time we will focus on the part that has been labelled and is feeling bad, empty or beaten down in some way. Again, look at that part and extend your compassion to it, not in a sorry or pitying way but simply with a desire for it to recover from its suffering and to flourish. Then, using kind thoughts, focus on the belief that it can and will recover.

Experiment with different exercises, perhaps combining them, and seeing which ones seem to work for you. The more effort and reflection you put into your practice, the more you are likely to benefit because you are taking control to retrain your mind. Remember the essence of yourself is like your consciousness, your spotlight – not what it illuminates. The feelings are feelings in you but are not the essence of you (see Chapter 7).

Further ways of helping ourselves change

This chapter explores some other options for working against depressive thoughts and feelings and trying to change our brain states. It might be helpful to try some of the exercises in the previous chapters first, so that you have some experience of identifying your thoughts and generating alternatives, before you try the ideas here, so see how you go.

Flash cards

Flash cards can be used as reminders of the sort of useful things that you tell yourself when you are feeling depressed. To make a flash card, take a blank postcard or a similarly sized piece of paper. On one side, write down one of your most typical negative thoughts; then, on the other side, write down some key helpful alternatives to this. Repeat this exercise for the depressing or anxious thoughts you usually have.

For example, suppose that you have the thought: ‘I will never get better.’ On a day when you don’t feel quite so bad, write out this thought on one side of a card. On the other side, write down what you imagine you might say to a friend who had such a thought, or how you imagine someone who cares for you might speak to you. Remember, consider these ideas not with a cold mind but with as much warmth and friendliness as you can muster – as if someone who cares about you is encouraging you to make your journey out of depression. Here are some alternatives to try:

- This is a very distressing idea. However, it is very common for depressed people to think and feel like this so it is natural and normal to feel like this because I am depressed.
- I can therefore just be mindful of this thought and feeling and see it as being produced by the depression. I can let the idea be there without running away trying to avoid it or dwelling on it and assuming it is true.
- This is typical of all depression – it always looks on the dark side. I am one with others on this.
- Because I feel like this, it does not make it true or a fact. The evidence is that people do recover from depression. I can be accepting of this thought, see it as an understandable thought – but not a fact. I can stand to the side of it.
- Although I (understandably) want to feel really well right away, I might be trying to achieve too much. Maybe I could aim for a little improvement and work with that, step by step.
- Focusing on the idea ‘I will never get better’, although understandable, will make me feel worse. It would therefore be preferable to focus on what I can do rather than what I can’t. How can I act against this belief and practise redirecting my attention and my behavior?
- It could be a good idea to distract myself from dwelling on these thoughts, perhaps by listening to the radio, taking myself out for a walk or doing some gardening. While doing this I will try to focus my attention mindfully on the activity.
- If I learn to go step by step, I might learn to get more control over my depression. Let’s really

give it a go and see how far we can get.

When you look at these ideas, how do they seem? Are there ways of discounting them running through your mind – as is typical in depression? Are you thinking, ‘Yes, but’, or ‘This might be okay for other people but not for me’ or ‘It’s too simple’? If you are having these thoughts, remember – this is the depression speaking. What have you got to lose by trying? How might you be kind and understanding to your dismissive thoughts, but not let them decide your actions or take control? What happens if you read them through but focus on ‘hearing them in your mind’ in as kind and warm a way as you can? Why not have a go?

Let’s try another typical depression-maintaining thought that involves self-labelling: ‘I am a bad, weak or inadequate person for being depressed. I never thought it would happen to me.’ Your flash card might list some of the following:

- There is nothing bad, weak or abnormal about me because I am depressed. Up to one in five people could have times when they feel like me.
- Many celebrities and people in high places (film stars and politicians) have suffered from depression. Depression can’t be about weakness if all these people can get depressed, too. Winston Churchill suffered from de -pression, which he called his ‘black dog’, and he was hardly a weak person. It is to do with our brain design.
- I would not speak to friends like this. I would try to understand and encourage them. Labelling them (and me) bad or weak does no good at all. It is just another form of bullying.
- When I get depressed, I focus on all my bad points. This is usually to do with my frustration or disappointment. The time has come to learn to be kind and understanding of my setbacks and my frustrations.

You can carry your flash cards with you, in a pocket or handbag, and take them out to give you a boost and help. Some people find pinning cards up in particular places around the house can be beneficial. For example, a woman I know who wanted to lose weight and had trouble controlling her snacking put a card on her refrigerator. It read:

So you feel like a snack right now? But think about this. Do you really need it? Would you feel better if you resisted the urge? Have a cup of tea instead. Hold on and you will be pleased with yourself tomorrow.

By reading this every time she was tempted to snack, she gained that little bit of extra control.

Compassionate cards

A slight variation of the above flash card idea is the following. Find a postcard or photograph that you really like, with a picture that gives a calm and soothing impression. One woman chose a picture of a mountain which she thought conveyed strength and calmness. Another chose to make her own card from some paintings and coloured paper. Choose any picture you like – it might even be one that makes you smile. Since you know what your depression thoughts are, you don’t need to write those. All you need to do is write down your alternative compassionate thoughts (maybe like the ones we tried above) on the back of the picture. When you are happy with this, then look at your picture, create a soothing rhythm in your breathing and

adopt a kind facial expression. Read your alternatives, then flip the card and look at the picture and try to feel soothing and acceptance for you. Try that a couple of times. You can use your card when you're feeling distressed – don't forget that slight smile and kind facial expression because this will be stimulating muscles in your face and feeding back into your brain. With practice, you may find it helpful. As for all of these ways of working with your depression, try them out and see how you get on. Introduce your own ideas for working on your depressed brain state.

Preparing yourself for stressful situations

If you know that you have something stressful coming up, you can prepare for it in advance. You can use flash cards as reminders for coping. For example, suppose you are going to have people over for a meal. One response might be, 'Oh God, it's too much. I'll never cope.' You could write down some key coping thoughts before the event:

- Maybe it won't be as bad as I think. Let's get the evidence.
- I can break down what I have to do into small steps. Each small step might be 'do-able'.
- Filling my head with 'can't do' thoughts is understandable but it would help if I refocus my attention and thoughts (see pages 190–95).
- I can develop a plan of action. I can rehearse the relaxation skills while I'm doing it and see if that helps me.
- I can learn to accept and tolerate my anxiety and feelings without running away. I can remind myself I have coped with these in the past. It's the body getting into its anxiety routine. I understand that this is extremely unpleasant, but not dangerous.
- I can focus my attention on what I'm doing. If I start to criticize myself, I'll say, 'Look, I'm doing okay' and really focus on that – and okay means 'okay', not necessarily marvellous.
- When the guests arrive, I can give them drinks and ask them about themselves. People like to be asked things about themselves; the focus does not have to be on me.
- If I feel tense during the meal, I can work on my relaxation. I can get up, go to the kitchen, or go outside for some air. I am not trapped here. I am free to go where I want – it's my house.
- I can deliberately practise imagining it going reasonably well, and feeling pleased, rather than only imagining it going badly. The aim is to show myself that I can cope and this is all I want to do right now. I will avoid all-or-nothing thinking (i.e. it has to be great or it's a failure).
- Each step of the way, I will focus on doing okay. I can do my best to keep my inner helper with me and praise myself for any small success.
- Practise making a real commitment to change and take on the challenge. Think about and build an image in your mind of how you will feel when you do.

The aim of this kind of work is to help you to prepare for things that you might find difficult. The more you try focusing on coping, the easier it may get.

If emotions could speak

Some depressed people say that they do not have clear thoughts going through their minds, only feelings. I remember once driving to work feeling rather down. At first, I could not focus on anything in particular, so I used the technique of, 'If my feelings could speak, what would they say?' I tried to get my 'down' feeling to tell me what was wrong. As I followed this idea, I found that I could begin to identify what my down feeling was about. It said, rather out of the blue, 'Your life is going nowhere.'

You're getting old now and your chances have gone.' As I followed this thought, I recognized that it had been triggered by playing cricket. Through my thirties, I had been too involved with work to play the game, which I had enjoyed in my youth, but had taken it up again in my mid-forties. Although I'd been a reasonable player when I was at university, I wasn't now. Compared to the younger players, I was a lumbering oldie with a poor eye for the ball. I suddenly realized that I was grieving for my lost youth! In fact, my thoughts were not really accurate about what I was really feeling. I was not actually worried about my life going nowhere (I was doing quite well, in fact) but was upset about losing my youth. Sometimes our thoughts are *not* actually accurate reflections of our feelings. When we allow our feelings to speak freely, they can take us to some strange and interesting places.

So if you can't identify thoughts but you can identify feelings, say to yourself, 'If my feelings could speak, what would they say?' Speak out loud the things that come into your mind; let the ideas flow. As you allow your thoughts to flow, be aware of them but avoid trying to direct them anywhere. Be mindful. See what comes up, what passes through your mind when you focus on the feelings. Be prepared to draw a blank sometimes, or for thoughts not to make much sense. The idea here is to allow yourself to go on your own journey of guided discovery.

Speaking with different parts of ourselves

So far we have talked about having depressing thoughts, anxious thoughts, angry thoughts, rational thoughts, compassionate thoughts and so on. Sometimes it is helpful to think of these thoughts as if they represent different parts of ourselves, and use an approach that allows us to name these various 'parts' or types of thoughts (see pages 87–8). Self-critical thoughts can be called the 'internal bully', self-supportive thoughts can be named the 'inner helper', 'compassionate image, friend or nurturer' and so forth. If we give space to these inner selves (types of thoughts), it allows us to observe and listen to the different types of conversations going on inside us. The point is that we are not one-dimensional beings, and in many situations we can have a mixture of thoughts and feelings.

Sometimes we can learn to pay attention to what different parts of us are saying by using different chairs. For example, sitting in one chair we become one part (e.g., the angry self, or anxious, sad or critical self). We give full voice to the thoughts, concerns and feelings. Then we get up, take a few steps and a soothing breath and sit in a facing chair and become the wise, compassionate self who has listened intently, is understanding and helpful. Pay close attention to the thoughts that flow here. If not much comes then imagine speaking to someone else for a moment – someone you care for – and also make a note to practise becoming the compassionate self more often.

Something else you might find helpful is a 'playful' style, playing each part as if you were trying to win an Oscar. This is not at all easy when we are depressed, but this does not mean we cannot be playful and take our inner thoughts less seriously.

A word of caution – if your self-critical side is not only your own disappointment and put-downs but also reminds you of someone who was very hurtful or harmful to you, then your compassionate side needs to be assertive and stand up to the 'voice from the past'. This can be tough and may need to be worked through with help or a

therapist. As always, only go with these exercises insofar as you find them helpful to you (see page 303).

Changing depressive images

When we are depressed, we often feel as if we are in a deep hole or pit and our internal images are very dark and harsh. Because this internal world can blacken our lives, it is sometimes helpful to work with these images directly. If you feel in a deep hole, imagine a ladder coming down to you and that you are climbing out, rung by rung. Practise the imagery before sleeping. It would be nice to jump out in one go, but that's only possible for a superman or superwoman and I have yet to meet one of those. Each time you succeed at something, that's one more rung up the ladder.

If your inner image is dark, try imagining getting some light in by installing some windows, or build a door and get out. Try not to accept the image passively, but start to change it so that it becomes more healing.

Carol had thought about getting out of a difficult relationship and coping on her own, but her internal image was always of living in some dark, cold place that nobody ever visited and which she never left. She thought that some of her dark images might have had their origins in being left in a cot in a dark room as a child. By focusing on one of these images and using active imagination (i.e. moving into the image), it became clear how dark this image of being out of the relationship actually was. Then it became possible for her to explore and change the image. She imagined what she could do in this place to change it, how she would like her own place to look, how she might decorate it, what pictures she might put on the walls, what flowers she might buy, what friends she might invite around, and so on.

The key thing about images is that, once you have a sense of them, you can work on how you would like them to change. Avoid simply bringing the image to mind and then feeling worse because you are not working to change it. It is changing the image that is important.

Sometimes people enjoy painting. People who are depressed tend to paint dark pictures, but it can be helpful to paint healing ones. Think about the kinds of images that are healing. These may be of a country scene, or of water – a seascape, for instance. Again the key idea is to acknowledge the dark images but also to introduce light and healing.

Changing values

We learn some of our values and attitudes because important people in our lives have told us that some values are good or punished us if we did not conform to them. Our attitudes towards sex, religion or the expression of anger are often learned in this way. Sometimes we adopt values by copying others, even those in society in general. For example, there is concern today that thinness is so highly valued as a female trait that many young women are getting caught in over-restrictive diets that can spiral into eating and weight problems. We take certain of these values into ourselves (i.e. we *internalize* them) and they become our own values and the ways that we judge ourselves.

Getting out of depression sometimes means that we have to reexamine our values and our attitudes. This may be enormously difficult and painful because we may lose our sense of who we are and have to accept new risks. To make matters worse, we may feel a great sense of disloyalty in changing our values from the ones our parents have given us. Sometimes we cling to values that are quite harmful to us because, in the back of our minds, we still hope to succeed with them and make our parents (or others) proud of us.

Sam had a high need to achieve and do well because his father had told him that only achievement counts in the world. Sam knew that his style of pushing to achieve, achieve, achieve and his intense self-criticisms were doing him no good, and he also worked out that the voice of his inner critic sounded very much like his father. And yet, despite this insight, he could not let go of the idea, 'If I don't achieve anything, I am worthless.' For him to give up these values required him to give up the idea that he would, one day, get it right and prove himself. That had always been his hope, and to abandon that seemed like letting his father down and leaving himself with nothing in life to aim for. It took a long time for him to see that, while achieving things was nice and gave him a buzz, it was not helpful to base his whole self-worth on it; that putting all his eggs in one basket was a severe restriction on his sense of worth; and that his father had been wrong to imply that Sam was nothing without achievement.

To help you explore these sorts of issues, write down two columns. In the first, write down the values that you think that you have learned from others. In the second, list the values you would like to impart to someone you love – e.g., a son or daughter. Table 15.1 shows an example.

Far from being weak or no good, depressed people are often following their values to the letter, bending in every conceivable way to make them work. If they fail at this, they don't re-examine their values but attack themselves vigorously. In fact, it is the strength of their efforts to maintain their values that can, at times, drive them into depression. The main problem here is that, although they may 'fight' the depression, do all the things they believe they should do and stick rigidly to their (learned) values and judgements, they end up enduring their depression but not actually changing it. They think that, with a little more effort, they will win through. But challenging depression may mean exploring values and attitudes that are no longer useful, such as our tendencies to overwork or over-commit ourselves. Working hard to get well may mean working hard to change some of our attitudes – not just following them more vigorously.

TABLE 15.1 ATTITUDES AND VALUES

Possible attitudes/values I have learned from others in my life	Attitudes I would like to impart to someone else (e.g. a child or friend) to help them be happy
You should not express anger	It is important to be able to express your feelings and not hide them. Anger can be turned into assertiveness. It is also about being honest with yourself and others
Other people's needs are more important than your own	Everybody's needs are important. If you only attend to others, you will become out of touch with your own needs and become just a servant. Eventually you will get depressed and be less able to care for anyone
Being depressed is a sign of weakness	Depression is a painful state of mind that needs to be understood. Throughout history, many millions of people have been depressed

Life scripts

Another way to think about attitudes and values is to tackle them in the form of *life scripts* or as typical roles we easily slip into. These offer us an identity – a sense of the person we are. For example, think for a moment about what kind of person you are. Try completing this sentence

I am the kind of person who _____

You may have many endings, not just one.

What did you come up with? Did you have things like:

I am the kind of person who cares for others/is a hard worker/should never show anger?

or

I am the kind of person who always loses out/gives in/gets left behind/fails at the last hurdle?

or

I am the kind of person who waits to be chosen rather than actively chooses/does not show off?

Perhaps you had much more positive ones too. The point about life scripts is that they are like parts in a play. At times, it can seem as if we are performing a part written by someone else. We might even blame fate. Over the next few days ponder on how you might answer this question and see if any new ideas come to your mind. See if one of your life scripts – a role you play, such as ‘do as others want’, or ‘Mr Angry’ seems to repeat. If so, write these repetitions down and think about where this script might have come from. Gently consider what you would have to do to change it, how might you act in different ways if you had different values. To begin with, play with a few ideas.

Another life script you might try is:

I am the kind of person who is not or does not _____

Here you might write

I am the kind of person who is not selfish/deliberately hurtful to others for fun

or

I am the kind of person who does not enjoy sex/put my needs first/cheat on others

and so on. Forming an identity often means discovering things we think we are and things we think we are not.

If you identify a life script – a style of living that makes you ‘you’ – think about how you might wish to change it. What would you need to do? Can you go some way towards being more as you would like to be? Recall that change can be slow, step by step.

KEY POINTS

- You can make flash cards with depressing or upsetting thoughts and then compassionately note those and generate alternatives to act as reminders and to refocus your mind.
- Allow your emotions to speak. Give them a voice and then explore their inner meaning.
- Use empty chairs to enable yourself to express out loud the various types of thoughts that might be going through your mind from the different parts of yourself.
- Consider some of the images that you have in your mind when depressed and introduce more soothing and healing images.
- Consider some of your basic life values and attitudes and decide if they are useful to you. For those that aren't, change them by thinking about the values you might want to impart to someone else. Those values are more likely to be your own genuine values and attitudes.
- All of us live out various roles or 'life scripts'. These can be changed if we give ourselves the space to consider what they might be and how we might tackle them step by step.

EXERCISES

These have been discussed within the chapter (e.g., making flash cards). The key point is to be as supportive and encouraging as you can and to see this as something to practise.

PART IV

Special Problems Associated with Depression

In this section, we will apply the ideas discussed in Parts II and III to specific problems in depression, some of which may apply to you and some of which may not. The chapters in this section can be worked through in order, but it's not essential. If you don't understand certain sections, skip them and come back to them later. Some chapters cover the same ground and similar issues, but from different points of view.

Approval, subordination and bullying: Key issues in relationships

Approval

We begin Part IV with the issue of approval because desires to be approved of, accepted, included, wanted, recognized, appreciated, valued and respected are often at the heart of many of our personal conflicts and worries when we're depressed. When we explore other problem areas, such as shame, anger, disappointment and perfectionism, we will find that the issue of approval from others and fear of the opposite – criticism, rejection or marginalization – is often in the background, if not in the foreground.¹

Before we explore how needs for approval are often tied up with depression we need to understand one thing. Humans have evolved to be a very social species whose very survival has depended upon the care, support and friendship of others. We even have special systems in our brain that monitor what we think others think about us, and will often try to work out if people like or don't like us. Seeking approval is something all humans do. Otherwise, the fashion industry would get nowhere! Think, for a moment, what our world would be like if no one cared what others thought of them, if no one worried about gaining approval – and yes, there are some people who seem to be like that.

Feeling cared about and wanted can affect us in many ways. When we face crises or tragedies in our life it's our ability to turn to others and feel supported and comforted by them that can help us get through. The problem is that because of early life difficulties or current life stresses, we can come to feel so alone and different that we become very dependent on other people's approval and support. There is also good evidence that for some people not having anybody to talk to or share feelings with may be associated with depression.

We also know that in an effort to feel accepted and win approval people can sometimes become very submissive and focus on pleasing others. In that way they get out of balance with self-development and social connectedness. Yet other people who really would benefit from talking about their feelings and opening up to others actually close down and withdraw as they become depressed. This is sometimes due to feelings of shame, fear of being misunderstood or a sense of being a burden, or sometimes because, for them, being with other people means they would have to put on an act.

Competing for approval

Much of our competitive conduct is related to gaining approval – whether it be passing an exam, winning a sports competition or beauty contest, or even having friends say nice things about our cooking. We often do these things to court other people's approval, to feel valued. Children compete and compare over the latest cool clothes, music or video games. We want other people to see us as able, competent, or cool, to raise our status and standing in their eyes. Be it with bosses, friends or our lovers, we want them to think well of us. We also have a need to belong to groups and to form relationships, and so avoid being seen as inferior or rejected. Indeed, people will do all kinds of crazy things to win the approval and acceptance of others, be this of friends, parents or even God.

We can start to feel a bit depressed if we feel this competition is going badly and that compared to others we're not doing so well. This takes us back to social comparison, discussed in Chapter 3 on pages 276–81. Feeling that other people are doing better than us can stimulate our envy and rumination and sense of inferiority. This in turn can drive the desire to win approval.

Approval and self-judgements

We are biologically set up so that other people's approval and acceptance can help us feel good and their disapproval and rejection feel bad. However, we are likely to meet both during our lives and so we need to work out how to deal with both. Unfortunately, our need for approval can become a trap when we pursue it to an excessive degree. We can become rather submissive – overly trying to please others (people pleasers), panicky if we don't and – worse still – self-critical. We also might not be able to cope with conflicts and disappointments in relationships. Even our nearest and dearest can be disapproving some of the time, or fail to notice things about us that we would like them to give special attention to. Sometimes they are just in a bad mood, of course. For example, Liz had a new hairstyle and hurried home to show Carl. He had liked her old hairstyle and was unsure about the new one, so he was cagey about whether he liked it or not. Liz felt deflated and started to think, 'I thought he'd really like it but he doesn't. Maybe I made a mistake. Perhaps other people won't like it either. Why can't I do anything right?' Liz started to feel inadequate with herself and angry with Carl. Note how Liz's disappointment turned into:

- All-or-nothing thinking: 'He doesn't like it,' rather than 'He's unsure' or 'He likes it a little' or 'He may come to like it when he's used to it.'
- Overgeneralization: 'Others won't like it,' instead of 'I like it and the people in the shop said it looked good. Just because Carl is unsure doesn't mean that everyone won't like it.'
- Self-criticism and self-attack: 'Why can't I do anything right?' instead of 'A hairstyle is a hairstyle and not evidence that I do things right or wrong.'

Can you see here how Liz's disappointment and frustration is fuelling this self-criticism? Liz could simply recognize the disappointment and leave it at that, rather than use those feelings to be critical of herself.

A helpful way to cope could be to compassionately recognize and accept this as disappointment.

Oh, this is disappointing as I was hoping Carl would like it – so it is understandable to

feel a bit deflated. He usually comes round, but even if not, I like my hair and it is helpful for me to start accepting what I like even if others are less sure. This is helping me become more my own person and this can help our relationship.

So learning to cope with this difficulty is actually an opportunity for growth.

Some people have feelings of inner emptiness if they do not constantly gain the approval of others. Wants, wishes and what were once thought to be good ideas seem to evaporate the moment another person does not go along with them or seems to disapprove. If this is the case for you, think about the possibility that you can start to find your own self by exploring your own preferences. Search inwards rather than outwards. Review the section on the empty self on pages 308–13. Ask yourself what things you can value that do not depend on other people's approval. Even if someone disagrees, this is not 'all-or-nothing' – it is not the case that they are right and I am wrong.

Mind reading

When we become depressed, we can need so much reassurance that we become extremely sensitive to the possibility that others do not like or approve of us – they might be deceiving us. Sometimes we may engage in what is called *mind reading*² (see pages 207–8). In this situation, rather small cues of disapproval are seen as major put-downs or rejections. A friend hurries past in the street and does not seem to want to talk to you. If you are depressed, you might think, 'My friend does not really like me and wants to avoid me,' rather than, 'S/He seems rushed and hassled today'.

If you are unhappy with someone's attitude towards you (perhaps because they were critical or ignored you), it is helpful to reflect and balance your thoughts. You can go through a number of steps. Remember, the first step is always to be understanding and kind to what we feel. If somebody criticizes you or doesn't praise you when you were looking for it, acknowledge that this is upsetting. The more we are honest about our feelings, the more we will be able to work with them kindly. Once you have been kind, understanding and accepting of your feelings of disappointment or upset then it's possible to stand back and think about your situation in a range of ways. Remember that standing back and using your compassionate and rational mind requires you to consider some questions in a kindly way, with a genuine desire to help you find balance in your thinking and not become more distressed than you need be. Try some questions like these. Ask yourself:

- Did the critical remark or look really represent a major put-down?
- In truth, is it my anger that has got to me – even if I am not voicing it?
- Was that really to do with me or were they just in an irritable mood today?
- How would I have felt about it if I was not depressed?
- Am I mind reading and thinking that the person thinks more negatively about me than they actually do?
- Am I assuming that a small disruption in the relationship is a sign of a major breakdown in it?
- Am I thinking in all-or-nothing terms or overgeneral -izing? For example, am I saying, 'If someone cares about me, they must never ignore or criticize me.'
- What will I think about this event in a week's or month's time – am I likely even to remember it?
- Am I expecting others never to have a bad day and be grumpy or irritable?
- What is the most helpful thing for me to focus on now?

The subordinate self

The subordinate approval trap

The subordinate approval trap often begins when you feel low in self-worth but you work out that you can feel better about yourself if others approve of you. You set out on a life's task of winning approval – which, on the face of it, sounds like a good idea, but the way you seek to gain approval might involve various unhelpful things. For example, you might try to be what another person wants you to be. You might avoid owning up to your own needs or feelings. You might hide your anger. You might be overly accommodating, hoping that the other person will appreciate this. You might do things you don't really want to do but don't want to risk criticism or disapproval. This is a matter of degree, of course, because we all engage in these behaviors to some extent, but when we get depressed or when we are vulnerable to depression it can be to quite a large extent. Sadly, what can happen is that other people may get used to you simply fitting in, and the odd nod of disapproval can have you hurrying back to please them. You end up feeling like a doormat and worthless. You may also feel rather resentful after all the effort you put in. What do you do? Well, you'll go back to your old strategies. You know how to deal with feeling worthless – you try to win other people's approval, right? – and so around and around we go, as Figure 16.1 shows.

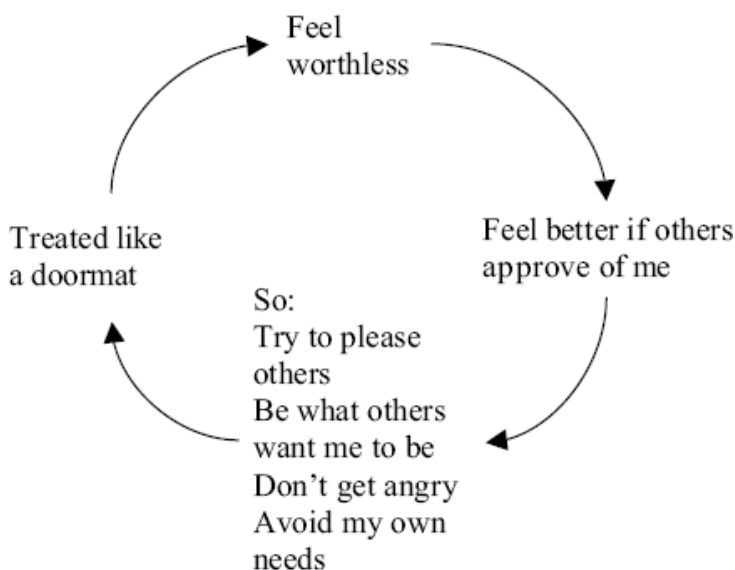


Figure 16.1 Feeling worthless circle.

Getting out of this circle requires that you are aware that you are in it, and that it is, to a degree, you who are setting yourself up for it. Next try to compassionately change the idea that you are worthless. Remember that this is a self-label (see Chapter 14) and is likely to be kept in place by your inner critic (see Chapter 13). Remind yourself that 'worthless' is a label and unhelpful. For the longer term your

compassionate mind can support you in a journey of growth and change. This might start with gradually thinking about, recognizing and of valuing your feelings, learning simple acts of self-assertiveness, learning to see how you can enjoy some time alone and doing things you *want* to do.

Understanding and coping with disapproval

Of course, approval may matter a lot when it helps us get a job or get on in a relationship. Again *we're all like this to a degree* – so it is a matter of degree. However, a serious difficulty arises when we make negative judgements about ourselves if we don't get the approval we want. Here's an example: You put what you thought was a good idea to others at work, but they are not impressed and said that it was poorly thought out. A flush of feeling that sweeps through you directs your thoughts to:

- Oh no! They must think I'm not very bright.
- This is terrible. I've damaged my reputation.
- I should have thought it through more.
- I am stupid to have opened myself up to such criticism.
- Why do I always put my big foot in it?

What has happened here is that the disappointment and concern with the criticism has sent a flush of anxiety through you. If you are new to the team you may (understandably) want to impress them. We need to be kind, understanding and accepting of the anxiety and then not let our more extreme thoughts go through our minds unexamined or untested out. It helps to learn to cope with this because the chances are you'll want to offer another idea at some point and don't want to be so anxious that you can't say what you want to say. Here are some compassionate and rational balancing ideas – but you may think of others that suit you better.

- These meetings are an anxious time, so it is only natural to feel anxious and cagey about this event. **It's quite normal** – the key thing is how I cope with this normal anxiety.
- Well, it's disappointing that my idea didn't catch on, but reputations are not damaged in single incidents like this. Maybe I'm upset because my pride's been hurt a little. I can live with that.
- Other people get criticized, too – not just me. This is how these meetings are.
- Nothing risked, nothing gained.
- The critic in the meeting tends to be like this with others – a bit bullying really.
- If I can learn to cope with this type of criticism, rather than telling myself how bad it is or how stupid I am, I'm going to be better able to cope in the future and it will increase my confidence.
- Even if I fail, this does not make me a stupid person. And in any case, failure is not all-or-nothing. There are parts of my idea that are still good – I just need to work on them more.
- My disappointment is masking the positive aspects of my self and what I can contribute.

You could also be honest with yourself and think about whether your desire to impress did indeed mean that you were a bit rushed and didn't think out your idea very well. If that's true then it's a useful learning experience. Be honest about that and move on with it. You might also notice some anger in being criticized.

When we make mistakes or get criticized it's helpful for us to refocus our minds and not ruminate on them. What can we learn from the experience and how are we going to change our behavior in the future to be helpful?.

A loss of identity

When we feel ourselves to be subordinate to others, that we are being used by them in a way we do not like, all kinds of changes happen in us. Beth and Martin had a good sex life. Martin was always keen, and at first Beth took this to mean that he really fancied her and she was a 'turn-on' to him. That made her feel good. However, gradually she came to think that, in other areas of their life together, he did not seem so caring. Eventually she had the thought, 'I am just a body to him'. This thought, of being used by Martin, and being highly subordinate to his sexual needs, had a dramatic effect on her. She lost all interest in sex, became resentful of Martin and wanted to escape. Moreover, she felt that he had gradually taken over her identity and that she had lost her own. However, Beth's thoughts got out of perspective as she became more depressed. Slowly she was able to change her thinking:

- It remains true that Martin fancies me and I don't need to discount that aspect of our relationship because I am angry with him.
- I can talk to Martin and tell him that I'm unhappy with other areas of my life.
- I can take more control in my marriage. If I feel exploited, maybe it's because I'm not asserting my own needs enough.
- Martin is not really an unkind man, but he is rather thoughtless at times. I need to help him be more attentive.
- Maybe it's my resentment and unexpressed anger that are also causing problems here.

It had been Beth's feeling used and unappreciated that had sparked off her negative feelings, but she had not had an opportunity to focus on them, challenge their extreme nature and take more control in her marriage. When she did this, she saw that there were indeed problems in the marriage, but she felt more able to try to sort them out. And perhaps she had rather allowed Martin to be inattentive for too long. What Beth also realized was that she and Martin needed to engage in more mutually enjoyable activities, not just sex.

A loss of identity can occur when we are in conflict about whether to live for ourselves or for others. Such conflicts can become all-or-nothing issues, rather than being faced as *difficulties in balancing* the various needs of each person in a relationship.

Nell gave up her job to have children and support her husband, but she gradually found this less and less fulfilling. Over the years, it had become accepted that her husband Eric should do all he could to advance his career, and in the early days, this had seemed like a good idea. But when he was offered a good promotion that involved relocation, Nell became depressed. What had happened?

Nell felt that she had lost her identity, she didn't know who she was any longer and she wanted to run away. She didn't want to move to another city but, on the other hand, felt she was being selfish and holding Eric back. Although for many years she had voluntarily supported him in his career, and at first had valued this, she gradually had come to think of herself as merely his satellite, spinning around him, and simply fitting in with his plans. However, she felt it was wrong to assert her own needs, and she was very frightened of doing or saying things that might be strongly disapproved of. Even her own parents said that she should do what she could to support Eric, and she worried about what they thought of her. As she became less satisfied with her position in the family, she found it difficult to change it because she thought she was

being selfish and 'ought' to be a dutiful housewife. She thought that doing things that might interfere with her husband's progress would make her unlovable. But re-locating and leaving her friends was a step too far. As for Eric, he was stunned by Nell's depression, for he had simply come to expect her to follow and support him. He had not learned anything different. In fact, Nell's depression was a kind of *rebellion*. But notice that this style had simply emerged between them and was *nobody's fault*.

The first thing Nell had to do to help herself was to recognize the complex feelings and deep conflicts she was experiencing. I recommended that she watch the film *Shirley Valentine* – in which a housewife goes on holiday to Greece with a woman friend, leaving her husband behind, and then decides to stay on. I suggested she could consider her depression as a kind of rebellion: not as a weakness or personal failure (as she did at first), but as something that was forcing her to stop and take stock of where she was and where she was going. An important idea was to see the depression as making her face certain things, and although painful, could be an impetus for change. When she gave up blaming herself for being depressed, and telling herself that she was selfish for not wanting to move house, her depression lessened. We then did some of the exercises for the empty self (see pages 308–13).

Sometimes people feel that they have to accept a subordinate position because they have lost confidence in other areas of their lives. This was certainly true for Nell, so the next thing was to explore her loss of confidence with her. She wanted to go back to work, but felt that she was not up to it. Underneath this loss of confidence was a lot of self-attacking – for example, thoughts of, 'I'm out of touch with work', 'It's been too long', 'I'm not good enough', 'I won't be able to cope', 'I might do things wrong and make a fool of myself.', 'Everyone is more competent than me'. Nell had also become envious of her husband's success and his independent lifestyle, but again, instead of seeing this as understandable, she told herself that she was bad and selfish for feeling envious.

Confidence is related to practice. Think of driving a car. The more you do it, the more confident you will be. If you rarely drive, you won't have the chance to become confident. It is the same for social situations. Women who have given up work to look after children can sometimes feel afraid of returning to work later in life. If this happens to you, think of whether you lack confidence because of a lack of practice. Be kind and compassionately gentle towards that. Avoid the tendency to criticize yourself. Work towards building your confidence compassionately, step by step. Get the evidence, rather than assume that you wouldn't be able to cope. If you give up too quickly, it may be because you are self-attacking.

Conflicts over how to live

If you can come to terms with a possible loss of approval, this will place you in a better position than before your depression. Other people will not be able to frighten you with their possible disapproval. Always keep in mind, though, that wanting approval is absolutely natural – and the need may increase when we are stressed or depressed. It does for me. It is how we manage this that is key, not whether we have those feelings or not.

Kim was married to a wealthy businessman. Before she came to see me, she had been given medication and told that her depression was biological. She herself could

not understand her depression – after all, she had as much money as anyone could want and her husband was not unkind. She thought she should be happy, but instead she felt weak for being depressed. Within a few sessions, Kim began to talk about how she had come to feel like a painted doll. She had to appear with her husband at important functions and often felt ‘on show’. Her husband was often away on business trips, and when he returned home tired, she felt that he used her to relax. She began to express her own needs, wanting to go to university and wear dirty jeans, as she said – but she also thought that her needs were selfish and stupid for a woman in her position and would court serious disapproval. She believed that, because her husband could provide her with any material thing, she was being ungrateful and selfish for wanting to live differently. She said, ‘Many people would be delighted to have what I have’. She also had many self-critical and self-doubting thoughts about going to university, for instance, ‘I’m too old now’, ‘I wouldn’t fit in’, ‘Others will think I’m odd’, ‘I’m not bright enough’, ‘I’ll fail’. Of course, she didn’t try to discover the evidence for any of these beliefs, and the depression was taken as proof that she would not be able to cope. They were more fears than facts.

When Kim began to help herself to get out of her depression, she started to:

- Learn to take her own needs seriously.
- Change the self-labels of ‘ingratitude’ and ‘guilt’ to ‘want to develop’.
- Avoid discounting the positives in her current life (e.g., ‘Nobody is interested in me for myself’, ‘I’m only a doll for my husband’).
- See her depression as a signal that her life needed to change, rather than as a sign of weakness.
- Understand how her thoughts were driving her further into, rather than out of, depression.
- Talk more frankly with her husband.
- Find out whether she could cope with university.
- Avoid attacking herself (especially in social situations).

Today I would do more compassion work too. Some people who feel highly subordinate to others can also feel so inferior that they think they don’t have the power to change. Once they can give up seeing themselves as inferior and inadequate, they open the door to change.

In a way, Kim felt as much subordinate to a way of life as to any particular person. Sometimes it is making money that causes problems, or maintaining a certain lifestyle. A couple may have become so dependent on money-making that intimacy falls away and tiredness rules. Both partners feel trapped by the demands to ‘keep going’. Sadly if relationships are subordinated to the need to make money, there is often a reduction in intimacy and happiness. There is increasing concern about these problems in our society today. The fear of losing a job can lead to working long hours; or there may be a need for two salaries. It is helpful to openly acknowledge this as a modern issue to be faced. Put time aside to ‘feed’ the relationship without this being seen as a burden. Gardens will grow whether you tend them or not but, if untended, you might not like the look of them as the years go by. Plan activities that are mutually rewarding and enjoyable. Spend time together on positive things, and show each other appreciation for sharing those things. Try to build on the positives rather than being separated by the negatives.³

Non-verbal communication

Our need to feel approved of by others begins from the first days of life. For example, babies are very sensitive to the faces of their parents. If babies are happy and smile at their mothers and they smile back, the positive feelings between them grow. But if a mother presents a blank or angry face, the baby becomes distressed. When mothers and babies are on the same wavelength and approving of each other, we say that they are 'in tune' or are 'mirroring' each other. Indeed, in adult life, approval is signalled not only by the words people use but by the types of attention they give, the smiles, facial expressions and nods. A smile or a frown can say a lot, and a hug can do much to reassure us. When we get depressed we can become sensitive to non-verbal communication.

Not only can we withdraw into ourselves and become rather unappreciative of others when depressed, but our own nonverbal communication can be very unfriendly. We look grumpy and fed up most of the time, and rarely think about how this will affect others. Yet when others become distant, we feel worse. Unless you are very depressed, it is often helpful to try to send friendly non-verbal messages – to smile and be considerate of others. You may protest, 'But aren't you suggesting that I cover up my feelings, put on an act?' The answer is yes and no. Yes, to the extent that you need to be aware that a constantly grumpy appearance is not a good basis for developing positive relationships – a depressed attitude can push others away. Moreover, if you smile and be friendly, this can affect your mood positively. However, the answer is also no, to the extent that, if there are problems that you need to sort out, then they need sorting out – don't hide what you feel. Being grumpy or sulky and making no effort to be friendly actually sorts out very little – it can lead to brooding resentment in you and others.

Entrapments

We can get ourselves trapped in relationships and then feel depressed and stuck because we don't want to upset people (see page 57).⁴ Steve had been made redundant, but a colleague he had worked for previously had set up a new business and invited Steve to join him. Steve had some doubts but needed the money and didn't want to let his colleague down. A couple of weeks into the job, Steve's concerns were realized. However, he felt his colleague had been very kind to help him out and that he would be turning his back on that kindness if he left – even though he now disliked the job. Steve became trapped by a sense of obligation, not wanting to let his colleagues down and also frightened they would see him as ungrateful. Gradually his sleep deteriorated, he became tired and anxious at weekends. Eventually, he was honest with his colleague who was very sad to see Steve go and tried to work out how to make the job better. However, Steve eventually found a job far more suited to his skills, and his depression receded in his new job. Sometimes our fear of upsetting people can trap us.

Of course there are many reasons for feeling trapped. For example, we may be in relationships we don't want to be in but don't have the money or alternatives to see a way out. Here it's important to recognize the feelings of entrapment and then find people to talk to – perhaps a family doctor – to explore how to cope and resolve the difficulty. Recognize that feelings of entrapment are not uncommon in depression, that these feelings are not your fault, and that while they can be difficult, they are

resolvable. Be cautious of thoughts such as ‘I shouldn’t feel like this’, ‘There is no way out’, ‘Things can’t change’. These are understandable feelings and thoughts, but if we are kind to them, acknowledge them but also explore around them, seek help, don’t take them at face value, we can never tell what lies ahead.

Giving approval

We can be so busy trying to gain approval and do things to please other people that we forget how to show appreciation of what they give us. For example, Lynne had a great need to be approved of. When I asked her how she showed that she valued her husband Rob, she said, ‘By doing things for him, keeping the house clean’. My response was: ‘Well, his approval of you makes you feel good, but what do you say to him about how you value him?’ Lynne went blank, then said, ‘But Rob doesn’t need my approval. He’s all right. Life’s easy for him. I’m the one who is depressed.’

When they were together, Lynne and Rob tended to blame each other for what they were not doing for each other:

Lynne: *You never spend enough time with me.*

Rob: *But you’re always so tired.*

Lynne: *That’s right – blame me. You always do.*

Rob: *But it’s true. You’re never happy.*

Around and around we went. Neither Rob nor Lynne could focus on how to offer approval to the other. Instead, they continually focused on their anger and thus there was little to build on. They rarely said things like ‘You look nice today’ or ‘It was really helpful when you did that’ or ‘I thought you handled that well’ or ‘You were really kind to think of that’. Lynne tried to earn approval but was not able to give it. It was painful for her to come to see that, in placing herself in a subordinate position, she felt that others should attend and approve of her, and she would work hard to get this approval, but she did not need to show approval of others. She saw them as more able than her and believed that her approval of them did not matter.

Depression can make us very self-focused in this regard. Sometimes depressed people are resentful of their partners, and giving approval and showing appreciation is the last thing they want to do. Don’t blame yourself for this but be honest and see what steps you can take to change. It can be useful, therefore, to consider how we can praise those around us – not just do things for them, but show an interest in them and recognize that all humans feel good if they feel appreciated and not taken for granted.

Being bullied

It is one thing to be criticized and to learn how to cope with it, but it is another to be on the receiving end of bullying. There is much literature on bullying and depression and an Internet search will reveal a lot of information, including advice on what to do. You could look at www.bullying.co.uk as a start. If you feel depressed because of bullying and want to escape, then recognize this as a normal response to bullying (our brains shift to threat mode big time) but get help; feeling bullied is even linked to suicide.

There is now much evidence that being on the receiving end of a lot of criticisms and put-downs (sometimes also called high expressed emotion) is associated with mental ill-health.⁵ These criticisms and put-downs can be verbal or non-verbal, or even physical attacks. Although it is common in depression to overestimate the degree and implications of criticism, it can also be the case that put-downs are not exaggerated. The problem then becomes whether anything can be done to change the situation or whether it is best to get out of the relationship.

Bullying and intimate relationships

Mark rarely said positive things to Jill, and acted as if he were disappointed in her. In therapy, he rarely looked at her but instead scanned the room as though uninterested in what was going on. Even when he did say some positive things to Jill, they were said in such a hostile and dismissive way that you could understand why she never believed him. The problem here was not only Jill's depression but also Mark's anger (rooted in his own childhood) and difficulty in conveying warmth. Many of his communications bristled with hostility and coldness; he saw depression as a weakness and was angry at Jill's loss of sexual interest. She came to dread Mark's moodiness and how he would look at her.

Sadly, Jill and Mark had become locked into a rather hostile and disapproving style. She experienced him as a disapproving, dominant male, and her life was spent trying to elicit his approval and get some warmth from him. When she failed, she blamed herself and became more depressed, with a strong desire to escape the relationship – which also made her feel guilty and frightened. She held the view that she should make her relationship work, regardless of the cost or how difficult it was. She prided herself on not being a quitter. But sadly, only if she subordinated herself to Mark's every need could she elicit approval from him. Moreover, she came to believe that all men were like this.

Problems such as these often require relational therapy. However, if you blame yourself for the problems or are ashamed of them, this might stop you from seeking help. If you feel frightened and are not sure where the next put-down is coming from, whether in a close relationship or at work, it is possible that you are caught up in a bullying relationship. The degree of your fear can be a clue here – although consider whether you would be fearful if you weren't depressed, because sometimes we become fearful of others because of depression. I have certainly come across many couples who fight a lot, feel resentful and so forth, but are not necessarily frightened of each other. So fear may be a key.

The first thing is to be honest with yourself and consider if a frank exploration of your relationship and its difficulties would be beneficial. Sometimes it is the bullying partner who feels ashamed about examining feelings of closeness and how to convey affection. Mark, for example, came from a rather cold and affectionless family and felt uncomfortable with closeness. He acted towards Jill in the same way that his father had acted towards him and his mother. As Jill came to recognize this, she gave up blaming herself for his cold attitude, and although this did not in itself cure her depression, it was a step on the way. She learned that trying to earn approval from a person who found it virtually impossible to give was, sadly, a wasted effort. Eventually the relationship ended.

So the lesson to be drawn from this is, don't blame yourself for another person's

cold attitude towards you. If you do, you are giving too much power away to the other person. Research has shown that a woman still living with an abusive partner will often blame herself for the abuse inflicted on her, but will come to see it as not her fault if she moves away. Try using the ‘responsibility circle’ (pages 284–6) and see how many things you can think of that might be causing the problem. What are the alternatives for the other person’s cold attitude?

Coping with violence

Obviously a more serious form of bullying is *domestic violence*. If this is happening to you then don’t suffer in silence; don’t self-blame or feel ashamed as sadly many people can suffer from this in their relationships. Reach out for help; for example, contact a national centre for domestic violence and speak to someone who can offer you support and advice (e.g., www.ncdv.org.uk). Remember the cardinal rules: honesty to your experiences, kindness and compassion for what you are experiencing, work out what you need to help you, give up self-blame and reach out to others.

Bullying at work

There is increasing concern today at the amount of bullying that goes on in families, schools and at work (see www.bullying.co.uk). Being on the receiving end of a bully’s attacks can be pretty depressing. As a society, we need to learn how to be more accepting of others and less unkind. As individuals, we also have to learn how to protect ourselves as best we can from the effects of bullying.

You can sometimes spot a bully because you will not be the only one who experiences his or her behaviors as undermining. It can be useful to get the views of others – get the evidence that it is not just you. For example, in the case of Jill and Mark, many of their mutual friends saw Mark as a ‘difficult’ person. When Jill thought about this evidence, it helped her to give up blaming herself.

Bullies at work can be very upsetting, because you can dread going to work or feel yourself stirred up each morning. If this is the case for you then try talking to someone such as your union representative or works doctor or another manager. Talk to others about how they cope, see if you can learn anything and also so that you don’t feel alone with it; maybe form an alliance with others. If you are able to move away, do so. The key thing is to avoid shaming self-blame for your reactions – rather work with them in as helpful a way as you can.

One key problem is *rumination*. We often ruminate on the bully – what was said and what we should say, and how angry we are and having to face them again! Over and over it we go. That is very understandable but will constantly stimulate your threat and stress systems. If you can spot yourself ruminating, note this as understandable but not helpful – and switch to a compassion focus as outlined in Chapter 8.

If sexual harassment is the problem, specific individuals may be picked on. Others may not experience the bully in the same way. If this happens to you, again, obtain support from others and be as assertive as possible. Raise the issue as openly and frankly as you can at work. Don’t be stopped from raising the issue with thoughts of, ‘It’s only me’. You may need legal advice. The more you are able to discuss this with others, this easier it may be to work out how best to cope.

KEY POINTS

- Wanting the approval of others is natural and makes the world go around. However, sometimes it is easy to become fearful of disapproval and then we can get caught up in a subordinate approval trap, becoming more subordinate, trying to be pleasing to others and sacrificing our own needs and wishes.
- We can become subordinate to the lifestyles of others, or even to a lifestyle we may have chosen at one time. This can lead us to feeling that we have lost our own identities.
- As for other aspects of depression we have discussed, the key is not to self-blame but be open and think through the main issues that might be linked to your depression.
- Sometimes we will need to reach out for the help and support of others, sometimes learn to be more assertive and sometimes develop courage to make change in our lives. All these will be easier (though not easy) if you are kind and supportive of yourself.

EXERCISES

You can explore how you deal with disapproval and criticism in a series of steps.

- First, begin with a relatively minor example of criticism. Bring that to mind. Now reflect on the feelings and thoughts that passed through you. Stand back from them, take a 'view from the balcony' as it were and clarify those feelings and thoughts. Think whether there are underlying fears, (e.g., that the person does not like you) or links to your past – do they remind you of an unkind parent, teacher or school bully? This helps you start the process of being kind to your sensitivity to criticism. You will be able to say to yourself, 'It's understandable that I feel upset by the criticism because . . .'
- Take a few soothing rhythm breaths and allow yourself to slow down for a moment. Imagine yourself to be a compassionate person; feel your inner kindness and wisdom grow; bring a gentle and kind expression to your face; give yourself expanding and becoming like a wise authority. From that position, consider ways in which you can think about the criticism and your reactions in a different way.
- If you find it helpful, write down alternative ways you can think about the criticism, which might include recognizing your sensitivity, balancing your thoughts so that you don't see this as a major rejection, recognizing the role of your own anger, remembering that these feelings pass, criticisms and arguments are part of everyday life, the other person might be grumpy. Would it help you to consider forgiveness (see Chapter 20)?
- Keep in mind that while rumination is easy to fall into and very under-standable, if you keep going over and over your upset, hurt or anger these repetitions in your mind are often unhelpful to you. Become mindful when they start up and watch them kindly.
- Be honest with yourself about whether you need to learn assertiveness. Sometimes we can struggle to be assertive because in our heads we become too angry or frightened, and rather than thinking about how to offer clear messages if we are upset by criticism, we just imagine getting our own back, or having a major fight. Since that is overwhelming, we can be stuck ruminating. If you feel like that be kind to yourself, smile at it and then think about what a compassionate and helpful approach would be.
- Think about how you deal with approval. Sometimes people who want approval are dismissive when they actually get it. It is almost as if they have to be constantly seeking but must never find; as if they don't know what to do with it when they get it. Think whether that's true for you, and if you have a tendency to constantly move the goalposts. If so, be kind to yourself but also make a decision to pay attention to small signs of approval such as smiles or small acts of friendship towards you. This is definitely a case where 'small is beautiful'. This helps us to give up trying to be some sort of super being and win super approval.
- As we have often said, the secret of success is the ability to fail (see Chapter 21). The secret of gaining approval is the ability to deal with criticism and disapproval. This is always tricky but if we can learn to tolerate criticism without ruminating, or deal quickly with our anger or fear, we will be better placed to deal with the ups and downs of relationships. It's tough, so go step by step.
- Put time aside to write a compassionate letter(s) to yourself to explore your issues about approval and how to work with it (see pages 233–9).
- Last but not least, if you are in a bullying relationship, be honest about it, speak with others and acknowledge that sometimes it's important to get away from the bully. Use your compassionate and rational mind to help you think through how to do that and to develop the courage you'll need.

Understanding and healing shame in depression

Of all the emotions that are likely to reduce our ability to be helped, to reach out to others and to treat ourselves with kindness, shame is the most important and destructive. Indeed, people can feel ashamed about being depressed, and desperately try to hide it from others. If we can recognize our inner shame and work to reduce it, we will do much to heal and nurture ourselves.

In general, shame – like embarrassment, pride, prestige and status – is related to how we think others see and judge us, and how we view ourselves. We call these *self-conscious emotions* because they relate to our feelings about ourselves.¹ The word ‘shame’ is thought to come from the Indo-European word *skam*, meaning to hide. In the biblical account, Adam and Eve ate of the apple of the tree of knowledge, became self-aware and realized their nakedness. At that moment, they developed a capacity for shame and the need for fig leaves – or so the story goes. Part of their shame was fear that, having transgressed against God’s instructions, they would be punished.

Shame is now regarded as one of the most powerful and potentially tricky issues in helping people with depression, because it often involves concealment or an inability to process ‘shameful’ information. People don’t easily reveal or talk about things they feel ashamed about – they’re worried about what others will think of them. Indeed, some people are ashamed of depression itself and this is why, sadly, they don’t seek help.

The elements of shame

Shame is a complex phenomenon, with various aspects and components. Among the most important ones are the following:

- **Social or externally focused thoughts and feelings.** These are beliefs that others see us as inferior, bad, inadequate and flawed; that is, others are looking down on us with a condemning or contemptuous view. This is linked to stigma and what we call external shame.
- **Internal negative self-evaluative thoughts and feelings.** These include beliefs and feelings that one is inferior, inadequate or flawed. Many of our self-attacking thoughts and feelings (e.g., I am useless, no good, a bad person, a failure) are in essence shaming thoughts and self-evaluations. This is called internal shame.
- **An emotional component.** The emotions and feelings of internal and external shame are various, but include anxiety, anger, self-disgust and self-contempt. Some people describe shame as a form of ‘heart-sink’ – the kind that sweeps over us when we’re hoping to succeed at something and then find we have failed!
- **A behavioral component.** Shame is related to the submissive response (that we share with

other animals) where we can feel small and looked down on, avert our eyes and try to make ourselves look smaller. There is a strong urge to hide, slink away, avoid exposure and run away. Sometimes we just want to cry. Often we can find it hard to think or speak. Sometimes, though, when criticised, we can show a much more dominating response of anger and want to retaliate against the one who is 'exposing' us or suggesting we're inferior, weak or bad in some way.

- **A bodily or physiological component.** Feelings of shame are stressful and activate our threat and stress systems. Shame also affects our mood chemicals and is not helpful in trying to foster positive moods.

The most powerful experiences of inner shame often arise from feeling that there is something different and inferior, flawed or bad about ourselves. We may believe that, if others discover these flaws in us, they will ridicule, scorn, be angry and/or reject us. In this respect, shame is fear of a loss of approval in extreme form.

We can feel paralysed by shame and at the same time acutely aware of being scrutinized and judged by others. Shame not only leads us to feel inferior, weak or bad in some way, but also threatens us with the loss of valued relationships – if our shame is revealed, people won't want to help us, be our friends, love or respect us. A typical shame-based view is, 'If you really got to know me, you would not like me'. A major feeling in shame can be aloneness. We can feel isolated, disconnected and inwardly cut off from the love or friendship of others. Shame can give us the feeling that we are separated (different) from others, an outsider.

Feeling ashamed and being shamed

It is helpful to distinguish in our minds internal shame (how we judge and feel about ourselves) from external shame (the feelings we have about ourselves when we think others are looking down on us). Let's look at this distinction with an example. Recall Anne from Chapter 9 (pages 190–3) who burnt her party dinner. She may be very concerned about what other people think, and worry that they may see her as incompetent and inadequate in some way. Her attention is focused on what is going on in the minds of other people and her social standing in *their minds*. This is external shame because the source of the criticism and the attention is outside (external) of herself. If she is *self-critical* and harsh *on herself*, maybe calls herself names and feels irritated with herself, then she will also have internal shame. The source of the criticism and put-down is coming from within our own minds. Table 17.1 outlines these distinctions and shows how they are linked to our key fears.

However, it is possible that Anne could be upset because she believes others look down on her but is not *self-critical* and accepts she's not a particularly good cook. Anne might have external shame but no internal shame. If Anne is convinced by the genuineness, if people reassure her, that they don't mind the meal being overcooked, she will quickly calm down, because she trusts others to still like and care about her. The kindness of others is soothing. Internal shame, however, is less easily dealt with because it's our own internal judgements, evaluations and feelings – and these we can find more difficult to settle. This is why it is important to learn *self-kindness*. Look back to pages 190–3 and note some of the suggestions for working on this problem.

TABLE 17.1 SELF-CRITICAL THOUGHTS AND FEARS²

External shame	Internal shame
<i>How I think others feel and view me</i>	<i>What I feel and think about myself</i>
These new people will see that I'm disorganized	I'm so annoyed with myself for forgetting such a basic ingredient
They'll not be very impressed with my cooking abilities or my organization	What's the matter with me? Why can't I get my head in gear?
They'll feel let down at having to eat a takeaway	The meal I cooked would have been so nice and impressed them.
I've probably blown it with them — they'll now always see me as a bit scatty and not take me seriously	I've really let myself down again by being careless and not paying attention
<i>Anne's key fear is: I'll not be able to make close friendships with people who respect me</i>	<i>Anne's key fear is: I'll not be able to make close friendships with people who respect me. I'll be marginalized and lonely</i>

In depression it is common for people to have both types of shame. They feel others see them as inferior, bad or inadequate; and they also see themselves as inferior, bad or inadequate. When you are working with your own sense of shame, then, it is useful to be clear about:

- What you think others are thinking and feeling about you.
- What you are thinking and feeling about yourself.

When you do this, you will see how often shame feelings are related to fears of loss of approval. In this chapter we will focus mainly on internal shame; that is, the kind of things you say to yourself that trigger feelings of shame in you, make you behave submissively and undermine your confidence.

Shame can affect us in many ways and we can defend against it in many ways. The first thing to recognize is that we feel insecure in the minds of others in some way. We're not sure whether they accept us or not. If we grow up knowing that others are accepting, validating and forgiving, we tend to be less bothered by shame than if we grow up in neglectful, harsh, rejecting or critical environments. If shame is a major problem for us, learning how to deal with it compassionately can help.

The focus for shame

According to the psychologist Gershen Kaufman,³ there are at least three areas in which shame can cause us much pain. We can feel shame about *our bodies*, shame about our *competence and abilities*, and shame in *our relationships*. There is an additional aspect that is especially common in depression: shame of *what we feel, or the things that go through our minds*. Let's briefly look at each of these.

Shame about our bodies

Some people don't go to see their doctors because of shame. There are all kinds of conditions that people regard as shaming: piles (haemorrhoids), impotence, bowel diseases, urinary problems, eating disorders, drink and drug problems. Shame, perhaps more than any other emotion, stops us from seeking help. There is general agreement that doctors could be more sensitive to shame, how to spot it and work with it.

Sadly, too, people who have various disfigurements – from mild acne to severe burns – can also feel shame, especially if others laugh at them, reject them or appear repelled by the way they look. But people cope with these in different ways (see www.changingfaces.org.uk/Home).

People who have been sexually abused often have an acute sense of bodily shame. They can feel that their bodies have become dirty, contaminated and damaged. In extreme cases, these individuals may come to hate and even abuse their own bodies. Talking about the experiences and feelings of abuse can in itself produce strong feelings of shame, and for this reason people may hold back from discussing them. Healing this shame involves coming to terms with one's body and reclaiming it as one's own (see below).

Concern with the way we look is, of course, a driving force behind fashion. However, some people feel so awkward and ashamed of their bodies that they will do almost anything to themselves to avoid suffering these feelings. People might spend hours body-building at a gym, and put great effort into dieting to make themselves thinner. Make-up and plastic surgery may also be used to avoid feelings of body shame. In the West today much depression emerges out of feelings of shame and unhappiness with the shape and size of our bodies – hence the huge dieting industry, which offers hope of change. Sometimes we can over-hope, in the sense that we might believe something like, 'If I lose weight then people will like me more and I will be happy'. If we try and fail, as people often do (I can't tell you how often I have tried to lose weight) then again that can feel shaming.

Georgie struggled to lose weight. She lost a couple of pounds then put them back on again. This caused a dip in mood and she was very down on herself and then ate more.

The issue about helping ourselves if we are overweight (and that includes me – unfortunately) is learning how not to shame ourselves if we don't do as well as we would like. We learn to be kind and understanding of our setbacks, while also trying to encourage ourselves to try again. If we are shaming of ourselves, we are much more likely to give up. Sometimes we need to simply learn to come to terms with the size we are and develop self-acceptance. At times, a bit of 'What the hell' in our lives can be helpful! (See page 501.) Think about joining a slimming organization because here you might receive help, guidance and a lot of understanding and support from other members. Talking to others helps us to see that we are all struggling with the same things – it not just ourselves – so we don't need to cover up or hide away.

TABLE 17.2 USING OUR RATIONAL AND COMPASSIONATE MIND

Rational mind	Compassionate/friendly mind (kind, warm tone)
Empathic understanding	
<i>My thinking is understandably clouded by my frustration and disappointment and also wanting to be like others. So the task now is how best to cope with this understandable disappointment.</i>	<i>It is understandable I feel frustrated because I put a lot of effort into losing weight and want to look slimmer and fit into those clothes. It is understandable that my attention will be on my weight because we live in a social world that makes so much of it!</i>
Here Georgie shows that she recognizes the problem as frustration clouding her feelings and thoughts. She is compassionate because she recognizes (is sensitive and sympathetic to) her frustration and disappointment as understandable and reminds herself why she feels like this. So she doesn't dismiss her feelings but accepts her disappointment with understanding – it is unhelpful to tell ourselves we should not feel what we do when we clearly do.	
Shifting attention	
<i>I can choose where I put my attention and I can do that according to how it will help me with my frustration 'in this moment'. Put time aside to practise redirecting attention in kind and compassionate ways.</i>	<i>If I stay focused on my weight I will become unhappy – so it would be helpful if I redirect my attention to other things. I can be mindful (see Chapter 7) of how these thoughts and emotions are playing in my mind. I can bring to mind the things that make me happy in life; these might be my relationships (bring to mind a picture of someone smiling at me) or things I do, or my garden. I can engage in soothing rhythm breathing, put myself in my compassionate self mode and just be compassionate to my distress – feeling kind. I can bring to mind a compassionate other image and imagine compassion and kindness flowing to me.</i>
Here Georgie is practising directing her attention in a different way and not letting her frustration dictate what dominates her mind. She is taking control and making choices about her attention and focus.	
Reasoning and thinking	
<i>Having a weight problem is very common because of the world we live in – that is not my fault. Humans evolved in times of great scarcity. We are designed to go for more and more rather than limit ourselves – so dieting is hard work.</i>	<i>With a friend I would help her to realize that it doesn't matter to me about her weight, I am interested in the quality of her as a person, whether I can trust her, share my values and stories with her. I would support her by recognizing how difficult</i>

<p><i>Because of our genes, different people lay down fat at different rates and also some find limiting their food easier than others — that's not my fault.</i></p>	<p><i>weight loss is, particularly in this world surrounded by wonderful foods, that the food industry has spent billions of pounds making us want to eat, and encourage her to accept the ups and downs of trying.</i></p> <p><i>It is easy for me to compare myself with thin women, because that's what all the magazines and our culture wants me to do, but actually this way of comparing myself to others is not helpful to me. The fact is I'm fatter than some people and slimmer than others.</i></p>
<p>Here Georgie is learning to reason and think about the issue rationally and fairly and then with warmth and kindness, thinking of how she would talk about this if it happened to a friend. She is recognizing that her compassionate, caring side sees things and thinks about things in a different way to her angry, frustrated, vulnerable side.</p>	
<p>Helpful behavior</p> <p><i>I can work out what went wrong and develop a plan to learn from the experience.</i> <i>The secret of success is really linked to the ability to fail. When I do not fear failure I'm free to succeed.</i></p>	<p><i>It is understandable why I might feel I don't want to be bothered trying to lose weight any more! This is my frustration and vulnerability talking.</i> <i>However, if I'm kind to myself and allow myself to settle down I know I'll come around again and have another go. So many of us have these battles. If it helps me I can ask people to come and help me, or join a support group. Let's see if I can work out another plan.</i></p>
<p>Here Georgie is thinking about compassionate behavior — behavior that will help her move forward, develop, learn from mistakes, grow and develop confidence. Compassionate behavior is about kindness, but is also about encouraging and being supportive in changing our behavior, taking on the challenges of change and not avoiding difficulties.</p>	
<p>To generate compassionate feeling, Georgie can now look through her alternative thoughts, engage in her soothing rhythm breathing and focus on the words but imagine a compassionate image, or a compassionate voice speaking the words. Here it is not so much convincing herself through evidence, but focusing on the kindness, support and understanding in these alternatives that is key.</p>	

Shame about our competence and abilities

This kind of shame relates to performing physically or mentally. For example Pete would become very angry with himself when he was unable to make things work. When household appliances broke down, he took it as a personal criticism of his abilities and manhood if he could not fix them. When his car wouldn't start, he would think that, if he were a proper man, he would be able to understand mechanical things and would be able to fix it. He hated taking it to the garage and showing his incompetence to the garage staff, and so always asked his wife to take it.

In my own case, my poor English has often been a source of mild shame. My teachers at boarding school would write in my report that I was lazy and careless. I could spend hours on a piece of work, reading over and over it, and feel confident it was 'spelted' correctly, only for it come back covered in red marks with comments

like, 'Slapdash, Gilbert!' – which then triggered that dreadful heart-sink feeling. Dyslexic children often experience much shame and feelings of being defective and inferior. The main point here is that attempting to do things and failing can be a source of shame. It is made worse when we rate ourselves as bad, and attack ourselves for failing. As a rule, it is easier to cope with the criticism of others if we don't attack *ourselves*. If we do, then there are attacks from the inside and outside and that can feel a very unpleasant place to be in! The next time you feel embarrassed at a failure, check to see if you are self-attacking and bring your rational/compassionate mind into play. My own experiences made me very aware of the power and pain of shame and why kindness and compassion are such helpful antidotes. I am also very grateful to copy-editors!

Shame in relationships

None of us like criticisms – although who is doing it and how it is done is important. However, when our shame sensitivities are touched we can become alarmed, anxious, defensive, angry, sulk or give in quickly. This can give us difficulty owning up to our vulnerabilities, for fear that, if others became aware of them, we would be marked down as weak and inadequate. Fear and shame of criticism can make relationships difficult because we find it hard to ride the ups and downs of relationships.

Some people feel awkward when wanting to express or respond to affection in the forms of gentleness, touching and hugging. It is as if there is an invisible wall around them. In situations of close intimacy, their bodies stiffen or they back away. Some may hide their shame by clinging to the idea that, 'Grown men don't do that sort of thing' or that to be tender is to be 'soft' and 'unmanly'. This can cause problems in how they act, as intimate friends, lovers and fathers. For example, children often seek out physical affection, and it can be very hurtful to them if their fathers push them away when they try to get close.

Shame about what we feel

We sometimes conceal our true feelings out of shame. We can be ashamed of feeling anxious, tearful or depressed or angry – as if the very fact that we have these feelings means that there is something wrong, flawed or unlovable in us. People with shame about their feelings can't believe that others have the kinds of feelings or fantasies they do.

For many years, Alec suffered from panic attacks. He dreaded going to meetings in case the signs of his anxiety showed. He was so ashamed of his anxiety that he did not even tell his wife. Eventually he broke down, became depressed and could not go to work. Then the story of his long suffering came out. From a young age, his father had told him that real men don't get anxious; they are tough and fearless. When Alec had been anxious about going to school, his father had been dismissive and forced him to go – shaming him in the process. By the time he was a teenager, Alec had learned never to speak of or show his inner anxieties.

Susan, who was married, met another man to whom she felt strongly sexually attracted. She flirted with him and would have liked the relationship to become sexual, but she felt deeply ashamed about her desires and believed that they made her a very bad person. As she came to understand that sexual feelings are natural, and to explore what it was about the relationship that so attracted her, she discovered a

desire for closeness that she could not get from her husband. This, of course, raised the question of what she could do about that; but it helped stop her being ashamed of her feelings and allowed her to accept that she, like other human beings, wanted closeness and could find a whole range of people rather sexy.

Jenny's mother had told her that sex is dirty – something that men enjoy because they are more primitive and superficial than women. Later, when Jenny had sex, she could sometimes push these thoughts aside, but afterwards she was left with the feeling of being dirty and of having betrayed her mother's values. When she monitored her thoughts during the day, she noticed that, whenever she had sexual thoughts and feelings, she would also have thoughts at the back of her mind of 'A good woman doesn't have these feelings. Therefore I'm dirty, and if my mother knew what was going through my mind, she would be disgusted and disappointed with me.' She then distracted herself from her sexual feelings and turned them off.

These were not clear thoughts as I have written them down – they were more sensed, and Jenny had to stop and really focus on 'what am I actually thinking here?' to get a handle on them. However, once she had come to recognize that she was having these kinds of thoughts (and she had to really focus to 'catch' them going through her mind), she was able to say to herself:

This is my sexual life and it does not belong to my mother for her to control. If I feel sexual, this is because I feel sexual, and it has nothing to do with being dirty. My sexual feelings also give me energy and are life-enhancing. I don't need to act out my mother's sexual hang-ups in my own life.

Andrew was ashamed of his homosexual desires. Brought up within a strict religious framework, he thought that these feelings were a sin against God and that he was a bad, worthless human being for having them. Although it was a struggle, he began to explore the possibility that there were alternative ways to think about and explore his sexuality – without being ashamed of it.

Gary was ashamed of his anger and rage. When he became angry, he felt terrible and unlovable. He said that he just wanted to act like a decent human being, and, more than anything, he felt that his anger made him a horrible person. Indeed, his self-criticism often told him that he was horrible, ungrateful, selfish and self-centred. As a result, he could not explore all the things that hurt him and the reasons behind his anger. Instead, he simply tried to keep a lid on his anger rather than acknowledge its source, go in to accept it and work out how to heal it. The dip in mood for feeling (or at times expressing) anger is more common in depression than is sometimes recognized. Indeed, Freud thought anger was central to depression.

At times, Patricia felt very tearful, but she would not allow herself to cry – she was too ashamed. Leo hid the extent of his drinking out of shame. Zoe was too ashamed to talk about the fact that her husband was abusing her. Amanda could not go far from her house just in case, when she needed to use the bathroom, there was none available and she would wet herself. There are many, many examples. For a moment let us feel compassion for all those who suffer with shame.

Crying

We often use the expression – 'it's a crying shame' – to denote perhaps that shame can involve tearful feelings and wanting to be loved. Let's look at crying and shame, because some depressed people really struggle with this. They see crying as a sign of

weakness or of falling apart and are ashamed. Table 17.3 shows some shaming thoughts and balanced/compassionate alternatives.

TABLE 17.3 ALTERNATIVES TO SHAMING THOUGHTS	
Shaming thoughts	Rational and compassionate alternatives
Crying is a sign of weakness	<p>Crying is a sign of pain and hurt, not of weakness</p> <p>Maybe it is our ability to cry that makes us human</p> <p>When we lose the ability to cry, we may lose the ability to feel and to heal</p> <p>Even if others see crying as a weakness, this does not make it true. Maybe they also have a shame problem about it</p> <p>After all, if we were not meant to cry, why do we have the physical capacity for it?</p> <p>Crying is often about feeling sad or lonely, and this is an important message to listen to</p> <p>The more I can acknowledge my tears, the more in touch with my feelings I may become</p> <p>So now let me be mindful with my tears – see what they are about – stay with them and be kind to them</p>

Sometimes people don’t realize (or have not had a chance to learn) that feelings can be complex; one can have *different* and conflicting feelings towards the same thing or person. Some people believe you should never be angry or want to leave a person you also love; that they should never annoy you to the point you want to shout at them, but that is the way of life.

If we have learned to hide our feelings in early life, then professional help may be useful to help us start to explore them more. But remember we all have feelings and some of them can seem very powerful – indeed overpowering or explosive. If you feel like that then that is not your fault (it’s to do with the way our brains are, and depression states) and once you give up self-blame you are freed up to seek out ways to help yourself.

Frightened and ashamed by our thoughts

Ever been in a high building or on the edge of a cliff? It is quite common for people to experience a feeling of being drawn towards the edge of high buildings with the thought of jumping off. This can be a bit frightening and we may wonder why we would have such frightening thoughts. But the fact is, given this tricky brain of ours, we can sometimes have thoughts that are in direct contrast to our true wishes. These thoughts and fantasies are called *contrast thoughts*. For people who have obsessional disorders, where such thoughts and images are common – they are called obsessional contrast thinking – thinking in complete contrast to one’s actual wishes. Another example is that we might have a violent thought about someone we love. Having

sexual thoughts or desires that seem odd or outside the norm can also be frightening. Contrast thoughts can intrude into our minds, can be distressing but are common.

If people feel ashamed of their contrast thoughts they may try to hide them or not think about them (which normally makes them worse), or ruminate on why they had them. Sometimes they can worry about acting out their thoughts, and this can link to a condition called obsessive compulsive disorder. Some people think that having a thought is as bad as an action. To address the shame aspect, you might consider that writers of horror stories write down their bizarre (and at times very violent) fantasies and thoughts and can *make a lot of money out of them* – whereas depressed people can be frightened of theirs. The writers know how bizarre our minds can be, while some depressed people think we should always be rational and reasonable. The fact is we have difficult minds to work with, and our minds can be filled with all kinds of odd ideas and fantasies – through no fault of our own! Learning how to notice them, accept them and let them pass, seen as products of our odd, evolved brains, can sometimes help. If they are more persistent you may find it helpful to talk with your family doctor.

The origins of shame

There are a number of theories about the origins of shame. According to one view, evolution has equipped children to enter the world as social beings with an enormous need for relationships, care, joyfully shared interactions and recognition. The treatment we receive at the hands of those who look after us will have a major effect on whether we move forward with confidence (the result of the many positive experiences encountered while growing up) or with a sense of shame, of being flawed, not good enough, lacking value or worth. Research has shown that the way the caregiver and infant interact has important impacts on the infant's nervous system, emotions and sense of self.

Shame can arise from at least three different types of reactions to the treatment we received from our parents or others who have cared for us in our early lives:

- thwarted efforts to be recognized as good and able
- pressure to conform
- direct attacks, puts-downs and rejections.

The need to be recognized as good and able

Consider the following scenario. Three-year-old Tracy sits quietly, drawing. Suddenly she jumps up, rushes to her mother and proudly holds up her drawing. The mother responds by kneeling down and saying, 'Wow – that's wonderful! Did you do that?' Tracy nods proudly. 'What a clever girl!' In this encounter, Tracy gets positive attention, and not only experiences her mother as proud of her, *she also has emotions in herself about herself – she feels good about herself.*

However, suppose that, when Tracy went to her mother with her drawing, her mother responded with, 'Oh God, not another of those drawings. Look, I'm busy right now. Can't you go off and play?' Clearly, this time the way that Tracy experienced her mother, the interaction between them, and the feelings in her -self

about herself were quite different. Tracy would be unlikely to have had good feelings in herself, and may have had a sense of disappointment and probably shame. Her head would have gone down and she would have slipped away. Thus *a lack of recognition* and a dismissal of ourselves, when we display something attractive to others, can be shaming. Experiences like this happen in even the most loving of homes and children learn to cope with them; but if they are common and arise against a background of insecurity and low parental warmth, they can, over time, be quite damaging.

One of my patients who read this section said that it brought back memories of herself as a child, when she would be sent to her room to play and ‘just keep out of the way’. Throughout her life, she had never felt wanted and had developed a sense of being in the way and a nuisance (see pages 313–16).

Donna’s parents were very ambitious. They wanted the best for her, and wanted her to do her best. If she came second or third in class, they would immediately ask who came first and indicate that coming second or third was okay but not really good enough; with a bit more effort, she could come top. Donna came to believe that nothing other than coming top was good enough to win the approval from her parents that she so desired. Anything less always felt like a disappointment for them and herself. You can guess what this all led to – an underlying belief and emotional sensitivity that, unless she did everything perfectly, she was flawed and had let herself and others down. Donna was rarely able to focus on what she had achieved, but thought only about how far short she had fallen.

Indeed, throughout life we seek the approval of other people, especially those close to us. If friends come to dinner we want them to tell us they’ve had a lovely meal – not that our meal was okay – average, they’ve had better and worse. We meet a new lover; we want them to say that our lovemaking was great – not that it’s average – they have had better and worse. The desires to create positive feelings in the minds of others is all very human – and we can feel a sense of shame if we struggle to do this.

Pressure to conform

We all have a very strong desire to conform and be accepted. We want to feel that we *belong* somewhere. We follow fashion and express the same values as others so that we can signal that we are one of the group. We follow gender stereotypes. We are highly motivated to try to be valued by others rather than devalued. All around us are values and standards to which we are supposed to conform if we don’t want to be shamed and stigmatized. The awful Chinese practice of foot binding, and other such practices of mutilation, can be kept in place via cultural shame to conform.

We may even try to avoid shame by going along with others, showing that we are made of the ‘right stuff’, even if, in our heart, we know that our action is immoral. Keith told me that getting into fights was often more to do with avoiding the shame of not fighting than with any real enjoyment in, or desire for, a punch-up; yet no one in his group wanted to ‘break ranks’ and point this out. Conforming to cultural values to avoid shame is a powerful social constraint. To risk exposure to shame is to risk rejection and not belonging. The pressure to conform can lie behind our cruelty to ourselves and others.

Direct attacks

We also know, of course, that children and adults can be shamed directly by being told that they are stupid or bad, that they don't fit in or are unwanted, and by being physically attacked. Indeed, some people will deliberately use the threat of shame, and the human built-in aversion to it, to control others. Shame does not only arise because approval and admiration are withheld; direct verbal and physical attacks can shame, too.

Let's look at this in more detail, because it will reveal something of the power of emotional memories. Imagine a child called Joe who has annoyed a parent. The parent shouts at Joe and tells him he is a stupid boy. Joe will have the following experiences: a triggering event and then awareness of the arousal of anger in the mind of the other (in this case the parent). That anger will be picked up by Joe's brain as threatening and dangerous, which will activate anxiety – even panic. Without thinking, Joe's brain will automatically be trying to work out the best defensive responses, such as anxiety, wanting to run away, head-down submissiveness and/or freezing. Note also that in that moment no one comes to help Joe; he is alone in this very threatening situation.

A host of different emotions and urges to do things (such as run away and hide) are being welded together. There is the awareness of anger in the other; there is the awareness that somehow his own behavior may have caused this threat from the parent to arise; there is intense anxiety arising in himself; there is a sense of aloneness and being isolated; there is an awareness that no one will rescue him; and of course there are the verbal labels of being 'stupid'. All these come together in that experience to form the core of an *emotional memory*. Like any powerful emotional experience and memory, it will influence our thoughts and feelings about ourselves and others, and our behaviors. The key point is to think about what Joe is learning about himself and others here. How easy will it be for Joe *not* to develop beliefs that he is stupid and that this 'stupidity' could get him into trouble? Not easy.

If the parent apologizes and explains their behavior, and at other times shows affection and praise, Joe can put this down to parental anger and not to himself, or that he is basically okay but needs to be careful at times. Problems arise if this does not happen, and Joe's most intense emotional experience of his parent is of anger and being labelled. Now in the future, criticism and anger in others could activate those emotional memories and feelings in Joe, including anxiety and a sense of aloneness. These feelings might flush rapidly through his body if someone is critical of him.

The point is, we can see how shame experiences can lay down powerful and complex *emotional memories* which can be triggered again in the future. Sometimes when we experience shame, and those heart-sink feelings, it is useful to think about the kinds of early experiences that might have made us vulnerable and then to practise compassion for those memories (see the exercises at the end of this chapter).

Sexual abuse

Sexual abuse has been found to be linked to chronic depression. In many cases where this is so, the people who were abused will often feel intense shame and be self-blaming and accusing – even though they were children or young adolescents at the time.⁴

The reasons for this are complex but can be a sort of self-protection because blaming the abuser can feel dangerous or confusing in some way. Clearly abuse can't possibly be a child's fault, because, as David Finkelhor pointed out some years ago, before anything happens, before the child is even involved, things are going on in the mind of the abuser. For example, there is the 'desire' in the abuser, and willingness to take advantage of a smaller person who will be in a relatively powerless position. The abuser has to overcome any moral scruples, and in today's society clear messages of wrongdoing. They need to manipulate the child into a position where they get them alone and can engage in the act, and they may overcome the child's resistance either with fear or some placating tactic: 'It's okay, this is a loving act really'.

In this book on depression we can't explore in too much detail how to tackle feelings of this kind of shame and self-blame. There are a number of books that specifically address this painful area.⁵ There are also phone and Internet helplines, some of which are listed in Appendix 3. What we can say is that, using a compassionate approach, there are a few things that might be helpful to consider. First, as noted above, abuse begins in the mind of the abuser. Second, if you think about the size and power discrepancies between the child and an adult or older person, it's clear where the power is. Third, we need to address the issue of shame, because sometimes people feel that only if they can convince themselves they were not to blame can they not feel ashamed. Books that put a lot of emphasis on why you are not to blame can sometimes imply that that's the only way to heal oneself of shame.

But in fact there is actually nothing to be ashamed about in sexual abuse. It may be tragic, terrifying, betraying, confusing, sad or 'just was'. Those are some of the ways people will describe how they experienced it. As Carolyn Ainscough and Kay Toon note in their book, there are different experiences.⁵ Some children are traumatized and terrified by aggressive threatening abusers. Others are seduced into going along with things that they're unsure about, or they might find their bodies behaving in what appear to be aroused ways. Keep in mind that sometimes we find our bodies acting aroused – because that's what bodies do. If I'm absorbed in a scary movie, even though I know perfectly well it is only a film I can't necessarily stop my body from being anxious. Bodily feelings don't obey any logic. And of course sometimes children can confuse affection in these interactions and go along with things – so it is not your fault.

There's a more important point still, far beyond blaming. This is that there is nothing to be ashamed of in being abused. It is sadly common throughout the world and has been for many thousands of years. It is a tragedy, something that might have been very frightening, a betrayal, a confusion, and a grief, but once you decide not to be shamed by it, you can become compassionate to your experiences and kind to your suffering.

Sometimes we won't let go of shame and self-blaming because it's a way for us to feel in control. If we really understand that it was not our fault and *we had no control*, this can be very frightening. Sometimes people say self-blame is the only way to make sense of it. I am all for making sense of things if they are genuine but there is no point in making up explanations – and when you would not make those blaming judgements if you were thinking about another child in your position. Our lack of control is the reality and the question is how we are able to be honest, humble

and acknowledge some of our limitations in this life. This is not easy, so do reach out for help.

Another problem is that our efforts to shame perpetrators can cast a shame shadow over the survivors. As one abused person said, 'Society regards sexual abuse as disgusting, therefore if people knew my past they would see me as disgusting.' Indeed it is not uncommon for people to feel ashamed because they are worried about how other people will see them if they discover their past.

Because of this, people can feel ruined or damaged; anger they might feel towards the abuser can be directed at themselves because of the sense of being scarred. They don't like themselves because they feel that other people wouldn't like them if they knew. However, it can help to open our hearts to the fact that hundreds of thousands of children in the world are abused, and have been throughout history. Indeed, in some places in the world today, marriage between young girls and older men is still allowed. Sexual desire towards children or family members creates tragedies and traumas but, I would suggest to you, not shame, and in your compassionate, wise mind I suspect you know this already – if you tune into it.

Let me show this to you. Consider that if you knew of a child or young person going through these experiences, would you want to point the finger, call them names and shame them? I doubt it. It is far more likely that you would want to reach out to them with gentle support, kindness and rescue. For those children who are suffering today we wish for them to be free of their suffering, not for them to be ashamed.

If you are struggling with these experiences, and you believe that they may well be part of your depression, then open your heart to recognizing you are one of many; there is nothing shameful in what happened to you. Remember abuse has been part of the human condition for thousands of years. Note too there are many trained people out there who are skilled and keen to offer compassionate help. Most reputable support helplines are completely confidential. You can ask about your situation and see if you feel safe enough to realize that, whatever the circumstances of your abuse, good therapists will never shame you but will help you work through it so that you can gently heal and value yourself. The key thoughts are openness and honesty, kindness and understanding for yourself. Compassionately work on any self-blaming or self-dislike, and reach out for help – your family doctor may also be able to help you with this.

The shaming loop

As we enter depression, we can get caught up in various circles of negative thinking and behavior, and shame can lead to several forms of self-perpetuating difficulties. At times, these can give rise to what I call a *shaming loop* (see Figure 17.1). This is particularly true of teenagers, adolescence being a time when the approval of peers and the potential for shame can have particularly significant effects. Many children are prone to being teased; some, sadly, more so than others. Coming to terms with teasing can be important for adolescents, and there are positive ways to do so, such as finding other friends or learning to ignore the teasing. Some individuals, however, turn to all kinds of things to ensure that they are not rejected in this way. Simon, for example, told me that he stole from local shops to give things to 'friends' so that he would be accepted and win some status or prestige from them. Sadly, through much

of his adult life he had felt that he had to give ‘tokens’ to others before they would accept him.

It is not always the case that feeling inferior leads to social withdrawal – but it can do, especially when people label and attack themselves. When feelings of inferiority do lead to social withdrawal, then such individuals are also more likely to be rejected because they signal their feelings of inferiority to others. Unfortunately, adolescents in particular, but also adults, do not find withdrawn behavior attractive. The very thing that these people were hoping to avoid – being seen as inferior and being rejected – can happen because of the way they behave.

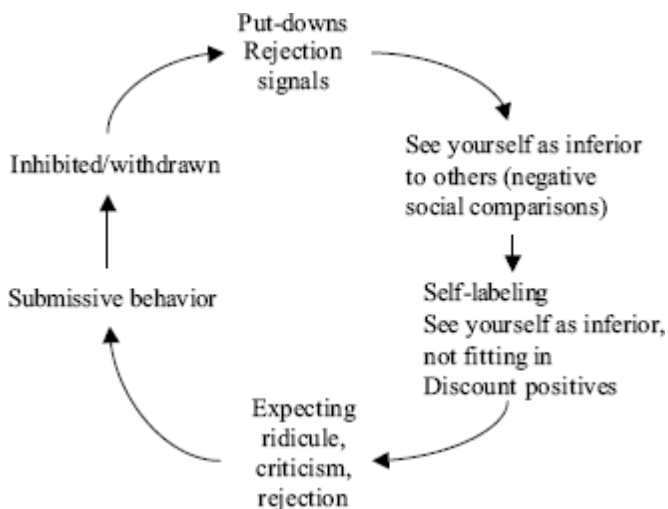


Figure 17.1 The ‘shaming loop’.

Heading shame off at the pass

If shame is so powerful, how do we cope with it? One way is to avoid it, by avoiding being seen as inferior, weak or vulnerable. You never put yourself into a situation where you could feel it. While the methods below may work for a while, problems can arise if they are adopted over the long term.

Compensation

This involves efforts to prove to yourself that you are good and able, and to avoid at all costs being placed in an inferior position. Sometimes we engage in vigorous competition with others to prove our own worth to them and to ourselves. It is as if we are constantly in a struggle to make up for something or prove something. Of course, we are trying to prove that we are not inferior, bad or inadequate and thus can be accepted rather than rejected. A therapist colleague told me (kindly) that this is why I write so much – but then, hey, we are all neurotic and it is how we use our neuroses that’s important. I like writing now because I have copy-editors who can save me from shame!

Concealment

This occurs when individuals hide or avoid that which is potentially shameful. Body shame (including shame of decay and disease) may lead to various forms of body concealment. In the case of shameful feelings, we may hide what we feel. Other people are always seen as potential shamers who should not be allowed to peer too closely at our bodies or into our minds. When we deal with shame in this way, much of our lives can be taken up with hiding – even hiding things from ourselves. We can repress memories because they are too painful and shameful to know and feel.

Laughter may be used to distract from shame. We may make jokes when we feel mild shame, to divert others' attention from it. When it is used to stop us from taking ourselves too seriously, joking can be very useful; but laughter employed to avoid shame often feels very hollow underneath. Some comedians use shaming humour which can actually be a cover for their own fragilities or anger.

Concealment can sometimes produce another form of shaming loop. For example, Janine would become defensive and irritated if the members of her therapy group began to talk about issues that touched her shame. This made the other group members irritated in return. They felt she was not being honest or facing up to her problems. This actually caused Janine to feel even more shame, and so she closed down even further. Thus her way of trying to hide her shame actually produced more shaming responses from others.

Violence

As I noted above, anger and blaming others can be a response to external shame: 'If you shame me, I'll hit/hurt you.' This is retaliatory shaming. Violence, especially between men, often arises as a shame avoidance strategy – a form of face-saving. In some male gangs it is the most important and powerful source of violence. Shame violence and feelings of humiliation can be acted out in many ways.

Ray had been caught stealing at school. When his father found out, he gave him a 'good thrashing'. What happened here is that Ray's father felt shamed by his son's conduct, believing that his son had disgraced him and the family. Not able to recognize or deal with his own shame, the father had simply acted out his rage on his son. This, of course, compounded Ray's shame and anger. Had Ray's father not felt so ashamed of his son, but instead been concerned to help him, he might have been able to sit down and explore what this stealing was about.

Natalie and Jon had a disagreement in public, and Natalie contradicted Jon. When they got home, he threatened her, saying in a very menacing way, 'Never show me up in public again, or else!'

Usually, shame and counter-shaming interactions do not reach the stage of violence. Nonetheless, they can involve a good deal of blame and counter-blame. Each person attempts to avoid being placed in the bad or wrong position. You might recall the interaction between Lynne and her husband Rob from the last chapter (see page 360).

Projection

Projection is used in two ways. The first is mind reading, where you may simply project your own opinions of yourself on to others. If you think that your

performance is not very good and label yourself as a failure, you believe that others will think the same. You assume that you are not very lovable, so you take it as read that others will think so, too. You feel that crying is a sign of weakness, so you think everyone else does, too.

A more defensive kind of projection involves things about yourself that you are fearful of or have come to dislike. You hide these from yourself, but see them in others. It is the other person who is seen as the weak, shameful one – not you. Condemning homosexual desire, for example, may be a way of avoiding acknowledging such feelings in oneself (which are feared), seeing them only in others who may then be attacked. Sometimes bullies hate the feelings of vulnerability in themselves and so they attack others in whom they see these feelings. Some bullies label others in the same way that they would label themselves if they could ever reveal their own vulnerability or hurt. Such people project those aspects that they see as inferior in themselves. Racist and sexist jokes can be a result of this.

If people criticize or attack you, it is possible that they see something in you that they don't like in themselves. For example, Sandra sometimes cried about feeling alone. Her husband Jeff would become quite angry at this, which Sandra took as a criticism of her crying. But it turned out that, as a child, Jeff had himself been criticized for crying. Not only did he view Sandra's crying as a criticism of himself (he thought it meant she was not happy living with him), but he also hated the feelings of vulnerability that might lead to *him* crying. Thus, Sandra's crying reminded him of things he was ashamed of in himself.

So, if people put you down or try to shame you about something (perhaps for crying or failing or needing affection), ask yourself: How do *they* cope with these things? How do they cope with crying or failing? If you reflect on this and recognize that they don't allow themselves to cry, or that they become quite angry when they fail, or that they have problems with affection, then it is wise to consider that perhaps they are criticizing you because they can't cope with these things themselves. Whatever you do, don't get caught up in the idea that they are right and you are wrong.

Shame, humiliation and revenge

We touched on humiliation a little above in the section on violence. Humiliation is similar to and different from shame. Both involve painful feelings, of being put down, harmed or rejected. We believe that the other person (parent, partner, boss) is sending signals that we are unacceptable, inadequate or bad in some way. This is external shame, but in humiliation we focus on the 'badness' in the other, not in ourselves.

Feelings of humiliation, where we feel unfairly criticized or injured, can ignite powerful desires for revenge. Indeed, you can tell the extent to which you feel humiliated by the intensity of your thoughts about the injustice done to you and the strength of your desire for revenge. For some people, their fantasies of revenge are frightening and so they are hidden away. In such cases, acknowledgement of anger is a first step. For others, the anger and desire for revenge are constantly present, and they need to discover ways to work through the humiliation and let it go.

You may be vulnerable to feelings of humiliation now because of things that

happened to you in the past. However, sitting on a lot of desires for revenge is not helpful to you. This is not to deny that very harmful things may have been done to you; rather, it is to say that if these feelings are not worked through, they can lead to a lot of mistrust of others and a tendency to constantly want to get your own back. This is a very lonely position and will keep your threat system stimulated by your vengeful thoughts. You can take the first steps to change by acknowledging your pain and hurt and deciding to seek help. You may also need to grieve for past hurts and losses.

It is one thing to have a desire for revenge on someone we do not care about, but what happens if it is someone you *do* want to have a close relationship with? Ted's father knocked him about as a child, and yet Ted also loved his father and wanted to be close to him. In therapy, Ted found it extremely difficult to recognize the feelings of humiliation that his father had inflicted on him and his own desire for revenge. Until he did recognize this, he was not able to move on to forgiving himself, for his vengeful thoughts, and forgiving his father.

Blocked revenge

Sometimes a strong desire for revenge that is blocked can be associated with depression. For example, someone has been physically attacked in the street or seriously injured in a car crash, but the guilty person gets off with a light sentence or evades arrest altogether. When we feel a grave sense of injustice that we cannot put right, we can feel terribly frustrated and defeated. People who experience blocked revenge can be caught up in awful ruminations and feelings, often leading to difficulties in sleeping. This continual brooding keeps the stress system highly active, as they go round and round in circles. Even if they know this, they may be understandably reluctant to give up their pre-occupation. Professional advice and support may help.

Becoming assertive

Sometimes dealing with shame is about becoming assertive. For example Kimberly often felt shamed by her husband's put-downs until she learnt to stand up to him. In working with depressed people we can find that shame and self-criticism can be covers for anger and that when they are honest about their anger the shame changes. For example, Anne's mother was emotionally neglectful and very critical, but insisted that she was a wonderful mother. So wonderful, in fact, that Anne was never going to be as good as her at anything! Part of Anne loved her mother and was frightened of losing her support or igniting her criticism, but it was not until Anne acknowledged that there was also a part of her that would like to 'smash her smug little face in' (and give voice to that in therapy) that she was able to begin to think about assertiveness – being compassionate and understanding to that anger was key to helping with shame.

Overview

Shame is a very important emotion, but like all emotions such as anxiety, fear and anger it can become problematic. It can become too easily triggered, too intense and last too long (because of how we ruminate on our sense of shame). It can be associated with unpleasant memories, bodily feelings and a flawed sense of ourselves.

How we learn to recognize and work with shame is key to healing our shame, learning from it, growing from it and moving on. In this chapter we have seen a whole range of ways in which we can experience shame and deal with it compassionately. Shame is part of the human condition.

KEY POINTS

- We all have the potential for shame.
- There are two types of shame. External shame is linked to the feelings we have if we think others are looking down on us, are critical, or see us as not worth bothering with. Internal shame is experienced when we are harsh and critical with ourselves.
- Shame grows in us when we label ourselves as bad, inferior, inadequate, etc.
- Shame can be focused on many things – on our bodies, our actions, our feelings. The origin of these feelings may be recent or in the more distant past.
- Shame can arise when we want to feel good about ourselves, loved, wanted and valued, but seem unable to elicit this from others and encounter criticism or rejections.
- Shame can be a paralyzing experience, and we may spend a good deal of our lives trying to conceal it or make up for what we think is shameful.
- Recovery comes from gradually acknowledging what we feel ashamed of, learning to treat it with compassion, and recognizing that many depressive styles operate in shame (e.g., discounting the positives, all-or-nothing thinking, overgeneralizing, self-labelling and even self-hatred).

EXERCISES

Exercise 1

Complete the following sentences:

- I feel ashamed about myself because _____
- I feel ashamed of myself when I do/fail to do _____
- I feel ashamed of myself when I feel, think or fantasize about _____
- I feel ashamed of myself because in the past I _____

Now that you have outlined some of the things you feel ashamed about, you can start to use your rational/compassionate mind to face these honestly and heal them.

To start with, write down some alternatives to the thoughts of shame you might have. For example:

I am not a bad/inferior/worthless person because _____

Here, focus on compassionate understanding, compassionate attention, compassionate thinking and compassionate behavior, and then generate compassionate feeling. Remember to open your heart to common humanity, that many humans have these kinds of difficulties.

Exercise 2: Opening to your compassionate mind

In this exercise, spend some moments quietly and engage your soothing rhythm of breathing. Feel yourself slow down. Focus on your compassionate mind (see pages 149–55). Remember this is what you imagine yourself to be – a deeply compassionate person. Imagine yourself expanding because not only are you compassionate, kind and gentle but you are also an authority and have wisdom; create within yourself a sense of strength and warmth. Allow yourself to have a kind facial expression and body posture. When you are happy with that method, imagine you can see in front of you the shame-self or the part of you that is feeling shame. See the eyes cast downwards. Allow compassion and kindness to engulf that part of you. Offer as much compassion as it needs. If your mind wanders or you feel it being pulled too much to the shame aspects, stop, pull back, regain your soothing breathing, refocus on your compassionate qualities of wisdom, strength, warmth and being non-judgemental, and then start again.

LETTING GO WITH GRATITUDE

Sometimes as people sit with their compassionate postures and imagine the shame aspect they can see

this part of them shrinking and moving away. This can be very helpful. Imagine that the part that feels shame is shrinking and moving away – getting smaller and smaller until it vanishes. But it is leaving *with gratitude for you* – with gratitude for you because you are releasing it and letting it go. You are not holding on to it any more. It can rest. It is the same basic ideas that we used with our tension; see pages 130–2.

Exercise 3

Try using healing compassionate imagery. Imagine yourself when you feel ashamed – nothing too major to start with: what is (or was) happening to you? Imagine that someone who cares about you has come to help you. What do you need from them? Ask for it. Imagine what they say to you – maybe they put an arm around you (if you like). Let their compassion sympathy flow to you. Decide how you will change to heal and grow from your shame feelings. Next, imagine how you would act if you were less shame-prone and think about the steps to take to make this come true.

Exercise 4

Sometimes it can be very useful to write a compassionate letter about things we are ashamed about (see pages 235–9). Remember this letter is written from the point of view of a wise, compassionate, gentle and kind self. Keep in mind that we all just find ourselves in this life, have been dealt different hands that we have to play as best we can. With this understanding and compassion, engage with your shame. Focus on compassionate attention, remembering times we have shown the more positive aspects of a personality. Consider your compassionate thinking and reasoning, and try to write a letter with a real desire to give understanding, compassion and gentleness. Sometimes these letters are difficult to write and you might have to try several times. Experiment and see how you get on, keeping clear in your mind that your goal is to bring compassion to your shame feelings.

Exercise 5

When we are ashamed we can back off from people and withdraw, so anti-shame behavior – operating against shame – is by engaging with others rather than withdrawing. You might also think about something positive you might do that your anxiety or shame might hold you back from. This might involve taking the first steps to initiate positive activities with other people. Decide if you are a person who waits to be chosen or are a chooser. Exert more control over positive choices, not just vetoes. Being able to stand up and resist things you don't want to do is important, but also consider being assertive in a positive way, to think about what you would like to do and how to make that happen rather than letting your lack of confidence hold you back. In this exercise choose something positive, it doesn't have to be very big, and go for it – learning to be kind, encouraging and supportive along the way.

Understanding and coping with guilt

Differences between shame and guilt

So far we have talked a lot about not blaming and not being self-critical, because condemning and blaming does not help us – but learning to be open to our limitations, mistakes and unkindnesses and be genuinely committed to improve and repair is very important for us in developing compassion (see Table 13.1). Guilt and the ability to be able to tolerate guilt can help us here.

Appropriate feelings of guilt are seen as more positive than shame because they are linked to wanting to avoid hurting others, the ability to think about *other people's* feelings, to moral concerns and genuine effort to make amends.¹ Guilt can obviously link to the legal meaning, that is, to mean one has ‘caused something’ to happen – but here I am going to contrast the psychological meanings of guilt and shame.

- Guilt has a different focus from shame. In guilt we usually focus on the *harm* or *hurt* we have caused other people by our actions, thoughts or feelings. Guilt can link to feeling *responsible* for others – to make them happy or protect them from harm. Shame, you will recall, is more about harm to oneself (being a bad, defective or unattractive person in some way).
- Guilt tends to focus on specific events – ‘I feel guilty because I did *that* or thought *this*’ – whereas shame is focused on feelings about the self, such as being inadequate, flawed or unattractive.
- In shame we want to hide and cover up, but in guilt we want to repair things and put things right.
- Guilt (often) arises where there are conflicts over things that we want, or want to do, that may harm others. Guilt is commonly associated with conflicts where one person’s gain is another person’s loss.
- To feel guilt, you have to be open to the suffering of self and others; to have empathy and sympathy and to experience feelings of sadness and sorrow (in contrast to shame’s anxiety, anger or denial) if you have hurt someone. These are not pure emotions because mostly we have blends of both.

To clarify these distinctions, consider the reactions of two men, John and Tom, both of whom have affairs. When their respective wives discover their infidelity, John thinks,

Oh dear, my wife will give me a hard time now. Maybe she won't love me so much. Suppose she tells our friends? How will I face them? I think I had better hide for a while and be extra nice.

John’s focus is not at all on the pain he has given his wife, but only on himself. His main concern is the damage the discovery may do to him (external shame) and

maybe he is not a nice person (internal shame). His response is shame-based. Tom, however, feels terribly sad for the hurt he has caused his wife and the damage he has done to the relationship. He recognizes how bad he would feel if the situation were reversed and feels remorse. Tom may also worry about his wife loving him less and what his friends might think of him if they found out, because principally he is focused on the harm he has done and the hurt he has caused and how he can help his wife. His response is guilt-based.

Some guilt feelings are often related to a certain kind of *fear*. The fear is the same kind of fear we might feel if we hear that someone we love has been hurt – it is based on a worry for and about them. When we have done something that has caused hurt or harm there can be feelings of sorrow and sadness, and these in turn are linked to feelings of remorse and regret. It is these feelings that make us want to put things right. For example, John may not feel very much sorrow for what he has done, because he is focused purely on the damage to him that may follow from the discovery. John's fear is that others will not like him. Tom, however, feels deep sorrow to see his wife so hurt.

You will note from this example that although Tom feels guilt and is far more in touch with the pain he has caused than John, he is unlikely to be free of shame. Suddenly, confronted with a deeply hurt wife, he may (perhaps for the first time) really appreciate how hurtful his actions have been, and this could trigger negative (shame-related) thoughts. Although this chapter is going to focus on guilt, we should be clear that guilt can trigger shame (and self-attacking thoughts, e.g., 'I am a cheat and a bad/unlovable person'); indeed, in depression it commonly does. Both guilt and shame are *self-conscious* emotions – meaning that they focus attention in on the self. The heightened self-consciousness of guilt can easily tip into shame and negativity when we are depressed. Guilt, as a trigger for shame, is important to spot.

Caring and guilt

The American psychologist Martin Hoffman sees guilt as related to sympathy and empathy: you need both to feel guilt.² Sympathy is when we are emotionally moved by another's upset or hurt; the wince if we see someone fall heavily or cut themselves. Empathy is our ability to put ourselves in the shoes of others and think about things from their point of view. However, without caring concern or some sympathy, empathy can be put to dark uses. Advertisers need some empathy to know how to hook us in to buy their products. Bullies might know how to really upset us because they can work out our soft spots and play on them. There is more to guilt than just empathy, and adult guilt must always involve some capacity for compassion and a desire to care for others – or at least not cause harm. This is why guilt cannot be understood purely by our thoughts. If we don't care about others, why would we be bothered with guilt? One does not need to care for others to feel ashamed, but one does to feel guilt. Indeed, one reason we can behave so badly and hurtfully towards others is because we don't have any interest in caring for or about the person. Similarly, if we stop caring or feeling sympathy for ourselves, we can also treat ourselves very cruelly and unkindly.

Guilt as moral emotion

I will explore how guilt can become a problem, especially when it is fused with shame – which it often is in depression. However, we should also be clear that guilt is an extremely important moral emotion. Guilt feelings can enable us to feel for others and be sensitive to hurting other people and truly want to make amends. Guilt is very much something to be open about, own and tolerate without turning it into a feeling of being a bad person (i.e., shame). We can learn to accept that sometimes our behavior is not so good! Guilt is when we focus on the other person(s) and care about them and our impact on them. Shame, however, is about our sense of ourselves.

Caring, reputation and approval-seeking

Guilt requires some emotional capacity for caring. It is not related to a status hierarchy or to feeling inferior in the way shame is. Guilt evolved along with our capacity to care for others. However, before we look at this more closely we need to clarify something important about our motives for engaging in caring behavior towards others. Not all acts of caring involve genuine feelings of care or sympathy. In fact, many don't. Sometimes we are kind and nice to others because we want them to think well of us. We want to have the reputation of being nice, caring people. We are caring because we want to be liked, loved or admired. This is approval-focused caring. If we fail at this, what we feel may be not guilt (because our motives weren't focused on the other) but shame: 'Oh no, I forgot Bridget's birthday party. She will think *I am* really thoughtless and be angry *with me*. Why *am I* so forgetful? *I am* stupid to make these mistakes.' You see how much is focused on the self?

Let's think about Tom and John again. Suppose John decides that he must be extra nice to his wife because in that way he might *win back* her love, or make life easier *for himself*, or because he might feel better *about himself* – this is approval- and shame-based caring. Tom, however, wants to help *his wife* to feel better. This is guilt-based caring. When we try to make amends only from shame, those around us can sense we are being nice for our own self-interests! So, in response, they might reject us.

So we can see that caring for others (being nice to people) and putting things right when they go wrong can be motivated by a desire to make ourselves feel better (shame-based) or to make others feel better (guilt-based). However, as in so many things, the picture is rarely black and white; in most cases it is a matter of balance, and our caring behavior is not purely of one or the other kind. Let's look at this more closely.

Rescuing heroes and self-sacrifice

For many people, doing a good turn for others and helping out when needed feels good, especially if others show gratitude and appreciation of our efforts. Letting our friends or family down, on the other hand, can feel bad. Trying to earn others' gratitude and thus feel good about ourselves is a typical human thing to do; we like to feel needed. For some, though, this desire can become exaggerated.

For example, David had fantasies of developing a loving relationship with a woman by rescuing her from a difficult life situation. The fantasy was vague. It could have been that she was lonely, or in a bad relationship with another man. He wanted to be someone's knight in shining armour and rescue her. The key point was that he felt that if he found a woman who needed him, then her *gratitude* to him would be the basis for love. He needed to be needed. As you might imagine, he was far more uncertain that he could be loved simply for himself – he had to be useful to a woman before she would love him. You can also imagine the kind of person he felt he had a chance with. He never thought he'd get anywhere with strong and able women, and he felt they would overpower him easily. Gratitude and appreciation are of course important aspects of affectionate relationships; but sometimes people set out to put themselves in relationships where they can earn gratitude – almost expect it, even – because getting others' gratitude and appreciation is the *only way* they feel loved. As for the partner – they do not want to be related to someone only out of gratitude – that becomes unpleasant!

Looking at the same desire negatively, we need others to be in difficulty so that we can rescue them. Some theorists see this style as developing in childhood, where children try to heal the wounds and difficulties of their parents and so to make their parents love them out of gratitude. This style can be called the *rescuing hero*. However, also note how our fantasies can involve obtaining other people's appreciation, gratitude or admiration for being able to make things better for them. How much of it is really approval-seeking? Saving the world from a disease or alien invasion is the stuff of many of our fantasies as children and (judging by Hollywood movies) adults too. We want to be heroic saviours.

Rescuing heroes are prone to burnout, exhaustion and hiding their negative feelings towards others. They may have problems with being assertive in pursuing their own wants and desires, through always trying to be 'so understanding' of others. Sometimes they try to avoid the more angry and aggressive feelings in themselves because they fear this makes them unlovable. Various writers have claimed that some people can care or love too much, and are vulnerable to depression because they behave too submissively. In fact, many books have been written on how guilt arises from an overdeveloped need to be nice, and can get in the way of healthy lifestyles. However, as many spiritual traditions point out, it is not really possible to love too much. In my view the problem is more commonly one of needing to be seen as, and to feel oneself to be, a caring person. We are too submissive and fail to look after our own needs.

If you think you are a bit of a rescuing hero and always try to look after others, the first thing is to be kind to yourself about this – let's face it, it's not a bad trait to have. Once you are kind and accepting of this tendency in yourself, the next thing is to think about how to bring more compassionate balance into your life. This may require you to spend some time gently thinking about what *your* needs are – then act on them, step by step. If you are into list-making then make a list of the ways you could bring a better self–other balance into your life. Or you could write yourself a compassionate letter on how to be more balanced and less of a rescuing hero.

For example, Tina always put her young children first and was often tired when her husband got home. She was not keen on getting babysitters, so their going out together had fallen away, as had their sex life. Her husband had gradually disengaged because she was very much 'mother hen' with the children and wanted to do most

things with them – so he felt a bit excluded. Tina came to realize that she was putting too much of her self-identity and sense of being a ‘good person’ into being the ‘perfect mother’. This was linked to feeling she had not been properly cared for as a child herself, but she came to see that she was neglecting her own needs and those of her marriage. Slowly she acknowledged she needed more help from her husband, especially at night, and also needed some space for her own interests. At first her husband was a bit annoyed because he felt she was pushing him even further away – but she had anticipated this and was able to accept his feelings and agree that maybe she had overdone the mothering role, but now needed his help. Step by step, and keeping a compassionate focus, they worked it out together. As she felt more able to have time and space for herself and she let her husband help out more, they rekindled their affections and thought more of themselves ‘as a team’.

Guilt, caring and depression

When people become depressed they can lose the capacity to *feel caring* towards others and then feel deeply guilty and ashamed about this. Sometimes when people become depressed they face up more honestly to the fact that some of their caring and ‘putting others first’ has been motivated by the wish to be liked, loved and approved of, and not necessarily from care or compassion for others. Third, guilt and the concern not to hurt others can create many complicated dilemmas in life that can also be traps. Let’s look at these links.

Losing the capacity to ‘feel’ for others

Depression knocks out many of our abilities for positive feelings. We can lose interest in ourselves, and in others too. Becoming aware that we have neither the energy to care nor feelings of caring can be a blow to our self-esteem.

Sam had been a caring man for his family and friends, but when he became depressed he felt unable to show interest in his family. His anxiety stopped him from doing things with them, like going on holiday, which previously he would have planned, organized and enjoyed. When one of his children informed him he was going to be a new grandfather he felt inwardly dead about it. Our conversations went something like this:

Sam: I just don't feel anything for anyone any more. I don't know what has happened to me. When Julia told me she was expecting I didn't feel anything. I know my reaction must have hurt her and I felt terrible about it. I would so much like to be there for her, but it just seems such an ordeal. My first thoughts were, 'Oh God, I am going to have to take the responsibility of being a caring grandad. I don't want the hassle of that.'

Paul: Well, sadly, depression can do this. And even when we are not depressed we can have such feelings and thoughts. But when we are depressed our inner resources are low and the body simply does not have energy to put into caring feelings. If there is no fuel in your car it does not matter how much you push the accelerator, it won't go anywhere. This does not mean the car is bad or deficient, only that the fuel tank is empty. We need to have a way of thinking about your loss of ability to care for others, 'to be there for them', so that your guilt does not become another source of self-attacking.

Working with this aspect of Sam’s depression was focused on his guilt feelings

about not feeling for others close to him. It turned out that he was often prone to guilt feelings and was normally very loving and sensitive to others. Sam was experiencing guilt for his lost abilities to 'be there for others' and was aware of how much his depression was hurting others. Yet he felt he could not do anything about it. Nor could he address some of his anger and difficulties in relationships because to do so felt like a betrayal and (of course) made him feel more guilty. His guilt feelings turned to shame; for example, he told himself he was selfish and an unlovable person. Therapy focused on seeing the depression as a brain state that turns off certain positive emotions.

Mothers can be especially prone to guilt when they lose loving feelings for their children. They tell themselves, 'I should not feel like this, I should always feel loving towards them'. Concern that their feelings and behaviors are harming their children can be a source of painful guilt. If this triggers negative ideas of the self such as 'I am a bad mother', then there is guilt and shame.

If you suffer from these kinds of feelings, then, as with so much I have tried to outline here, the key message is clear – *the loss of feelings is not your fault – it is sad and painful but absolutely not your fault*. We can be kind to our loss of feelings, and work out how best to walk the road of self-understanding and healing our minds.

Feeling a burden to others

Some depressed people feel that they are being a burden to others (see pages 313–16). They may even feel that others would be better off without them. This is a dangerous way of thinking, because it fuels suicidal thoughts. It is *never* true, because suicide leaves those left behind in states of sadness, loss, anger and confusion; they'll never forget. If you think like this, let me state clearly: this is the depression talking, and *it is never true*. Sadly, I have seen the damage a suicide can do to families for years to come. And when people recover from depression they are very relieved they did not harm themselves. If you think others would be better off without you, then you need to be clear in your mind that everyone, including you, would be better off if you could recover from your depression – that's common sense – but, no matter how dark your feelings are, *no one* gains from a suicide.

So let's be honest about this. Sure, depression is burdensome – but so are many other types of illness. We do not need to pretend otherwise. And we may become dependent for a while. When we are children we could not survive without being dependent on others. When we get sick we often need looking after – life is like this. There are times when we have to take as well as give. Sometimes we have to learn how to cope with being cared for, for a while; to learn that sometimes we have just run out of fuel and then we can't give out as much as we would like. If you are haunted by feelings of being a burden, then seek professional help as soon as you can. Tell yourself,

This is my depression talking. There is nothing bad about me for feeling this way. However, I can focus on what I need to do to get well rather than how bad (guilty and/or ashamed) I am for being depressed. There are over 300 million depressed people in the world, so it can't be my fault if my depression makes me feel this way. Let's go step by step and focus on what I can do rather than what I can't.

This is what we worked on with Sam from pages 411–12.

Paul: *At the moment you're preoccupied with the fact that you don't feel pleasure in your daughter's pregnancy, right? And you feel sad at this loss and the possibility that it hurts her?*

Sam: Yes.

Paul: *Okay, suppose you were to put that to one side; to admit, as you have, that your feelings are not functioning that well right now; that's sad for you, but what might you do that she would like?*

Sam: (thinks) *Well, I guess I would normally send her a card or something.*

Paul: *Okay. How would you feel if you did that?*

Sam: *Better, probably, but it wouldn't seem genuine. I should do this because I really want to, because I feel something.* (Note the underlying belief that all caring should come from a deep feeling of caring. We could have explored this belief, and later on we did, but here we took a different track.)

Paul: *Sure, if you weren't depressed you might well feel something. But look, we know that at the moment you won't, so there is not a lot of point in telling yourself you should feel something. Your feelings may come back as you recover. The first step is helping you do things that you want to do, regardless of what you feel. Feelings will be the bonus of getting well. So even though there may not be much feeling in it right now, sending a card would be something you could do.*

Because Sam was preoccupied with his guilt feelings about not feeling overjoyed at his daughter's pregnancy, but felt indifferent, he had been paralyzed and unable to act in ways he'd normally do. This made him feel even worse. By breaking into this paralysis we were able to help him begin to make changes and not expect that his behaviors should be matched with passionate feelings of caring. He went to the shops and sent a card and some flowers. His daughter was touched by this, and it was a small step forward. This also indicates the importance of doing things and taking action, even when you don't really feel like it (see Chapter 12). So compassionate behaviour can be more important than compassionate feeling.

We also learned from this exercise that Sam had been telling himself that if he went through the motions of caring then this was not genuine caring, and if it was not genuine caring it was a fake, and if it was a fake it was worthless. Remember how some people can be tormented by the ideas that their behaviors are fake (see Chapter 14)? Sam gives another example of this.

Sometimes people lose affectionate feelings for others (and feel guilty) because of unresolved conflicts of anger or envy. I will discuss these in later chapters; here we simply make the point that whatever might be causing the loss of caring feelings, there are things that one can do and ways of thinking about the problem that need not lead you into self-attacking. Ask yourself:

- Am I expecting too much of myself?
- Am I expecting my feelings to work as they would if I were not depressed?
- How would I feel if I were not depressed or stressed out?
- Even though I may not have much feeling for it, are there things I could do that would help me feel better?

Guilt, dilemmas and traps

Few of us take pleasure in purposely hurting others, especially those we care about, but sometimes this is inevitable and we need to face that. Carol had stayed in a relationship for some years because she could not face hurting John. She was fond of

him, but the love had gone out of the relationship some years earlier. Her mother had had a similar relationship with her father, and Carol had felt sorry for both of them. They had stayed together, her parents had told her, 'for the sake of the kids'. That of course put some burden on Carol, to think that mother and father suffered each other because of her. It is just as likely that there were many other complex factors in *their* psychology that made them cling to each other. For example, maybe they did not know how to build affectionate relationships.

Many children in such situations, far from feeling gratitude to their parents, can feel a sense of guilt. Carol was one of those people who felt it her role to make people happy. She was one of life's rescuing heroes. To be a cause of unhappiness (e.g., to John by leaving him) was almost unbearable. Also, as we noted above, guilt is most likely in times of conflict, where one person's gain is another person's loss.

No therapy can help people avoid dilemmas in life, and sometimes these are acutely painful. There are no right or wrong answers; no cost-free solutions. All one can do is help people think about their dilemmas in ways that allow them to move forward with them rather than get stuck in guilt and shame. In essence, Carol's psychology had set up a trap – sometimes called the compassion or guilt trap. She was not free to do what she wanted (to leave the relationship) because she felt too guilty about the pain she would cause John. Underneath this there was a bubbling resentment (for which she felt guilty) and depression. She could see no way forward.

Carol's therapy focused on issues related to her guilt and her inability to tolerate it. She had to acknowledge the painful fact that her guilt often led her to being dishonest in relationships. She would do things for others to avoid upsetting them. By the end of her therapy she had worked out that ending the relationship might be for the better. She would be sad about it, and John would be hurt, but if she stayed she would only get more resentful and depressed. Once she had faced the possibility that she could go, that she could face her guilt, sorrow and sadness, she felt less trapped. The therapy had loosened the bonds that were immobilizing her. I don't actually know if she did leave John, as their relationship had improved slightly through her being more honest with him; but she told me that she had more insight into what locked her into unhelpful relationships, and this released her a little. Maybe facing the fact that she *could* leave made the need to leave less urgent. I don't know.

Guilt and escaping

Just as we can feel a burden to others, so we can feel burdened and overloaded by the responsibilities of life. Not only may people lose interest in caring for others; as they get depressed they can have strong desires to get away from them, to escape. For example, a young mother who is not sleeping and has become exhausted may want to run away from everyone who is making demands on her. In our own studies we have found that desires to escape are strongly associated with depression.³ (See pages 57–8.)

If you have strong escape desires, then remind yourself that these are common in depression. Try to work out specifically what you want to escape from. Do you need to create more space for yourself and look after your own needs more? Worksheet 4 in Appendix 1 addresses this issue. Guilt about wanting to escape can stop people exploring why they wish to leave, or what they need to do to change their current situation, or even whether they would indeed be better off leaving or taking time out.

Guilt can lock us into circles of thought and feeling such as: taking on too much responsibility, we feeling burdened, then want to escape, then feel guilty; to cope with the guilt we try harder, but then feel more burdened – and so on. It's important to allow yourself to take an honest look at your life and see what needs to change to make you feel less burdened. Are you expecting too much of yourself? Do you take on things because you do not like to say 'no' – but then feel resentful and out of control? Have you become exhausted? Do you feel like this when you are not depressed? Imagine you were talking to a friend. How would you see it for them? How would you help them? What might a rational/compassionate approach be?

Being honest

Guilt can be like other emotions, such as anxiety or anger – we can feel overwhelmed. But fear and guilt can lead to dishonesty and serious difficulties. Abigail often felt a little intimidated by her husband and wanted to separate from him, but whenever she broached the topic he got angry and made her feel guilty. She withdrew more and more and started taking overdoses. One day she admitted, 'You know, I just hoped he would get fed up with me, find someone else and leave – that was my dream. I could not bring myself to be the one to walk out'. Abigail was also not entirely sure in her own mind if she wanted the relationship to end – but if her husband left her, that would relieve her of those doubts too. When she fantasized about him leaving her there was 'this enormous sense of relief'. She was also honest enough to acknowledge that part of her could then also play the hard-done-by victim.

These are not easy things to acknowledge in ourselves – they take courage – but we can be gentle and see that many people get caught in these dilemmas and struggle to be honest. It's not our fault – life can be tricky. However, once we give up self-blaming and face our sense of shame and guilt, and realize our dishonesty is not helpful, then we are more open to think how best to move forward. Ruminating on entrapment is a recipe for depression. In fact Abigail did eventually muster the courage to leave and some months later reflected on why she had not 'done it years ago'.

Guilt and a sense of deserving

People who are prone to excessive guilt will sometimes talk in terms of 'entitlement' and 'deserving'. Fairness and a sense of deserving are part of our psychology, but we must learn to keep it in balance. Some depressed people feel they don't deserve to be happy – that somehow if they are happy they will be punished for it. Folk who feel like this might have been made to feel guilty when they focused on their own needs and feelings. Some people can also feel tormented by guilt and shame because they can't enjoy their good fortune. Such a person may say, 'I've got so much going for me. I'm not poor, and I have a fairly good relationship with my partner, but I'm not happy. I feel so guilty that I can't appreciate things. Maybe I don't deserve them.' This is a bit like Sam from a few pages ago. Instead of working hard to find out exactly what they are not happy about, they keep telling themselves they 'should be happy' and feel worse for not being so. If this is the case for you, then write down

what you are satisfied with in your life. Then write down the things you are happy with. Recognize that there are things that you are happy with and things that you may not be happy with. Next, note that if you are unhappy in one area of your life this can affect the feelings about other areas – that's natural. If you break a leg, it doesn't matter how well the rest of your body is functioning, the broken leg still hurts like hell and stops you doing lots of things. Telling yourself you shouldn't be in pain because at least you don't have cancer does not help much. Of course, learning to appreciate the good things in one's life is important in depression because it helps us avoid all-or-nothing thinking and over-focusing on the negative, and stimulates positive feelings. There is not much to be gained by feeling guilty for not being happy. You can see then that the question of deserving does not enter into it.

Some people can feel guilt at wanting to fulfil their own needs; wanting more affection or time to do things with friends. One patient thought that wanting more personal space was 'kind of greedy'. Owning up to and trying to fulfil one's needs are normal, natural and important. The key thing is how to balance the demands on us, while also looking after ourselves and not burning ourselves to a frazzle!

Fear of enjoying life

We might need to acknowledge that some of us can develop a fear of pleasure and enjoying life. Sounds odd, doesn't it? But consider Kerry. She has many memories of enjoying herself, then something bad happening. For example, she recalled enjoying playing with friends in a garden, screaming with fun. Then her mother came rushing out and told her how bad she was as she had forgotten to clean her room, grabbed her painfully by the arms, told the other children to 'go home' and threw her into her room. Kerry said, 'If I feel very happy I am sure I will pay for it tomorrow or something really bad will happen. I feel I must never let my guard down.' In Kerry's mind good feelings were associated with bad outcomes. You can see how Kerry had learned to be frightened of feeling good.

Patricia only felt people cared for her if she was in pain or unwell – indeed, only if she were ill did she think that her mother paid the slightest attention to her. In her mind was the idea that being happy or well meant not being cared for or about.

So there may be all kinds of reasons why we feel guilty or frightened to be happy. In a quiet moment it can be useful to write these down, in a gentle and honest way. Ask yourself, 'If I was frightened or concerned with being really happy – what would my concerns be?'

Remember, too, that it's relationships that make us happy, not material objects. People make this mistake time and again. Just because you are wealthy or healthy (although these help, of course) is no guarantee at all of being happy. Indeed, I would suggest that often it is not so much happiness that is key, but that we can learn contentment and how to be at peace with ourselves.⁴ To help yourself with these problems you can:

- acknowledge that you may be wary of feeling happy
- write down possible fears and where these might have come from (why you are not allowed to be happy)
- think how you can test out these ideas and how to practise small steps for changing
- recognize that 'that was then, this is now' and it is time to retrain your brain
- make an effort to practise your 'change steps' allowing yourself to feel (a bit) happy each day.

Survivor guilt

Lynn O'Connor and her colleagues in San Francisco have studied guilt over a number of years and noted there are different types of guilt. One of these is *survivor guilt*.⁵ This type of guilt first came to the attention of researchers when it was found that people who had survived traumatic experiences such as being in a concentration camp or taken hostage, or survived a disaster could feel bad because they had survived while others had died or been seriously injured. They asked themselves, 'Why did I survive and others die?' Sometimes there was a feeling that they didn't deserve to live, or didn't have a right to be happy when others had died. Feeling happy made them feel guilty. A recent study has found that people who have survived a life-threatening illness and knew others who shared the condition but who did not survive, can feel not only sadness but also a depressing sense of not deserving or, 'Why me?'

Guilt at being better off than others

Lynn and her colleagues also reasoned that this kind of guilt can operate in many types of relationship where we find ourselves better off than others: for example, from an awareness that we have superior qualities, or better opportunities. Imagine that you and a good friend take an important examination, say to go to university or get a job, or you enter a competition like a beauty pageant. You are both keen and share your hopes of passing or winning. You pass but your friend does not – she fails. How do you feel?

There are times when we know that we can't do anything to help others; and knowing that others are suffering while you feel helpless to do anything about it can be depressing, especially if you are doing well yourself. Sonia had a good job in advertising and was over the moon about it. Her husband Dave, however, was not doing so well. His firm was going downhill and eventually he was put on short time. Sonia started to feel guilty about her success. When she came home she didn't share good experiences she had at work or her sense of how exciting it was, because she felt it would upset Dave and make him feel worse. She was also worried that Dave would resent and envy her for her good job. She loved Dave, but she also began to resent his low mood and anger at how things had turned out for him. Then she also felt guilty at feeling resentful. After all, things were going well for her. The guilt of upsetting Dave with her own good fortune stopped her from sharing things with him. As time passed, she found that she would stay longer at work to be with enthusiastic people rather than in the more subdued mood that prevailed at home – but this also made her feel more guilty. Key beliefs were: 'I shouldn't want to spend more time at work when I know that Dave needs me at home. I should be there for him. I shouldn't enjoy my life when Dave is not enjoying his. I am selfish.' Sonia needed to clarify the issues and recognize that, for her, wanting to be with enthusiastic people rather than a husband afflicted by envious low mood is natural. For Sonia, the important point was to help her see that labelling herself as selfish and feeling guilty about feeling resentment were unhelpful.

In some families, induced guilt is rife. Sonia had grown up in a family with a mildly depressed mother. As she entered adolescence and started to go out at night, her mother would often tell Sonia how lucky she was and how much more difficult it had been for herself when she was young. 'I never had the opportunities you have',

she'd say. Her mother would tell her how much she loved Sonia, not by noting how good-natured or talented Sonia was, but by pointing to all the sacrifices she (as her mother) had made for her! Sonia was unwittingly being trained to operate on guilt and gratitude. She came to believe that she should always put the needs of others first and that if others were suffering or needed her, she should be there for them. After all, she was so lucky, wasn't she? In therapy it is common to find that people who are sensitive to guilt, who feel uneasy with success and enjoying life, often have had depressed parents. They need to care for others, to help others; and quite often they gravitate into the helping professions.

As we have seen, then, when something good happens to some depressed people they often wonder if they 'deserve' it, have a right to enjoy it or are frightened to enjoy it. These thoughts are often not fully conscious, but are in the background of their minds. If you ever worry about showing off your talents because you fear that others will feel badly in comparison to you, and so you play them down, the chances are you are operating on some kind of guilt issue. You may also have a belief that others will *envy* you. 'If they see my good fortune or talents they will envy me or dislike me or try to pull me down.'

Just as some people feel they don't deserve their good fortune, and so sabotage their ability to enjoy life, so others are all too ready to use the idea of deserving to support and justify their good fortune. Some time ago the newspapers published the fact that a wealthy financier had been given a £3 million 'golden handshake'. When asked whether he was a 'fat cat', he responded with, 'No. I worked hard for my firm and deserve it.' No obvious guilt here. It looks like the banking system all over the world has been run by the 'give me more I deserve it, guilt-free' mob. How much more refreshing to have heard, 'Well, I have had the good fortune to be reasonably bright, with an ability for hard work; I've been given a good education and had the connections to get a good job.' As you see, the notion of 'deserving' is in the eye of the beholder.

Responsibility guilt

Many commentators note that we are surrounded by (some would say bombarded by) constant information about the need to be aware of the consequences of our behavior. We must be careful with our diet, be careful of our weight, look after our children properly, not buy commodities that might damage the environment or be made by child labour in the third world, be aware of our carbon footprints, open our eyes to the suffering in the world and recognize the terrible economic injustices – on and on. It is probably true that we are living at a time when we know far more about the consequences of our behavior than at any other time. Learning to be open to and live with these responsibilities without feeling burdened, becoming hopeless, controlled by guilt or going into a state of detachment and denial – these are interesting challenges for us. The depressing bit here though is usually social comparison – believing that we're doing less well than others at these things.

Lynn O'Connor and her colleagues have also pointed out that at times we take *too much* responsibility for other people, especially their feelings⁵ (see pages 283–8). For example, some women blame them selves for their husbands' drinking or violence. One woman felt that her husband drank because he felt unloved, and that if she could love him more he would stop. Thus in her mind she felt guilty for not loving him

enough to heal his inner pain. This kind of thinking, however, takes responsibility away from the other person and stops them having to confront their own problems. To put it negatively, we can literally rob people of their responsibilities. It is as if we were saying to the other, 'You are not responsible for your own happiness or bad behavior. It is all down to me. I am responsible for what you feel or do.' Put like that, it doesn't sound so good, does it? People can only grow and mature by taking responsibility for themselves. Although you may think that blaming yourself and feeling guilty is helpful or protects them, it is unlikely to do them much good in the long run. It is the same with our children – a key challenge is how to enable them to take responsibility for their lives.

In such situations it can be useful to draw out a responsibility circle (see pages 283–8). There may well be aspects of any situation that are indeed your responsibility and under your control; but always try to keep a balance here. Avoid all-or-nothing thinking: it's either me or them. Sometimes when people confront their own pain, especially if it's people you care about, you may feel sad for them. But this does not mean you have to feel guilty, as if you were not doing enough to help them. Support them, yes; but don't take on the responsibility for their change or healing their minds – only they can do that.

Saying goodbye

I discovered my own 'rescuing hero' side with a wise and kind supervisor who drew my attention to the fact that I was not discharging people from therapy as I should. He helped me discover my own thoughts along the lines of, 'Maybe I haven't done enough to help them. Maybe they will need me in the future.' I had mild guilt and shame feelings about discharging people because I might be abandoning them (letting them down), and so they would not like me.

When it comes to ending a relationship or separating from others, we often have many mixed feelings, and one of them can be the guilt of leaving and saying goodbye. Perhaps it is leaving friends or staff behind when we take a new job or maybe it is leaving a relationship that has had its day. Even parting with a beloved car can be tricky for some of us!

In the lives of some depressed people there is often a history of guilt at leaving their parents. When Ruth wanted to go away to study, one of the things that stopped her from going to her favoured university was the prospect of leaving her mother, who from Ruth's childhood had turned her daughter into her 'closest friend'. Although Ruth was close to her mother too, the relationship was fairly one-sided in terms of who was benefiting from it. Ruth remembered many occasions when she had not gone out with friends so that her mother wouldn't be lonely. Ruth had major guilt problems in separating from her mother, and thinking of her as 'being left alone'. But from the outside it was clear that unless Ruth had faced this, she would not have been able to claim her own life. Parents are responsible for their own lives and can cause children real problems by turning them into their carers or depending on them for friendship. For most animals, including humans, the role of the parent is to train their offspring to be able to enter the world, even at times to push them out into it. It is not to keep them away from it in relationships of dependence.

Grief and guilt

The biggest separation is, of course, death. When someone we love dies it is not uncommon to feel (at least a bit) guilty. We remember all the times we said unkind things; the times we could have done more for the person and didn't; the visits we could have made and didn't. This is all normal and not uncommon. We are only human, after all. However, sometimes there have been unresolved conflicts with the dead person and we feel painfully guilty that we were not able to sort them out before they died. Many Hollywood movies have been made in which relationships work out at the last moment before death and a reconciliation occurs. There are few dry eyes in the house, but that is Hollywood; real life is not often like this.

Guilt can be one of the many complicating factors in grief and can stop us working through our grief. The problem with guilt and death is that because the other person has now 'gone', we may see no way we can repair things or put them right. We feel blocked. If this is true for you, then getting counselling or therapy might help you move forward. As always, be aware of the negative self-attacking thoughts you might have.

Through talking to others, you may gain new insights and see possibilities for change. I remember a person early in my career who taught me a lot about how things can 'just happen' in therapy. We had been working on his relationship with his father and how they had not got on that well. When his father died, Ben felt intense sadness and guilt for a separation that had lasted for years and which neither had been able to heal. Then one day Ben had a dream about his father. I don't recall the details, but Ben came to therapy in a changed state of mind. He said something like,

You know, I can see now that both my father and I are proud men. Neither of us could share our feelings that easily. I see how much he suffered because of this. It seems so silly and pointless to me now. His death has brought home to me how important it is to say what we feel and not hide behind these barriers. By dying when he did, he has given me the chance to be different from him. In a way I guess that is a gift he has given me.

Ben was very tearful at this point. He had looked at his guilt in a different way, and had been able to learn from it rather than being paralyzed by it.

There can be times when a death is a relief. Maybe one has had to look after a dying person, whose death sets both free. Even this can induce guilt, however, as if we should not feel relief at the release from the burden of caring alongside the sadness of the loss. A hundred years hence, much that we see around us will be dead. This is the cycle of life. Death makes room for new life. The evolutionists have their views about it and the religious have theirs. The only point I am making here is that to feel relief at the lifting of a burden is natural to life. You may wish to focus on your sadness, but you don't need to be stricken by guilt.

Self-focused guilt

Can we feel guilty for things that harm only ourselves? The existential writer Irving Yalom, in his book *Existential Psychotherapy* – a fascinating work on these issues, including those associated with death – answers yes.⁶ In his view, to believe that we have not lived to our full potential, that at times we have taken the coward's way out

(my favoured way) and have not been ‘true to ourselves’, can induce what he calls existential guilt – that is, guilt for how we live our lives. We put up with things which in our heart we know we shouldn’t tolerate. One of my own self-guilt areas is in having been a smoker. In my heart I knew it was bad for me but I couldn’t face up to the effort and loss of pleasure to stop. I knew I was harming my body, and my family asked me to stop – and I was always going to, ‘next week’. This type of guilt is helpful to own and face up to, because it helps us take steps to change. When we deny it or pretend we don’t feel guilty for things we know can harm us, then we may be less likely to change. Having said this, it is usually better to find positive reasons to stop doing harmful things – guilt simply alerts us to the need for change.

Inducing guilt

Roy Baumeister and his colleagues have written about how guilt can work positively in relationships. Imagine what relationships would be like if we never felt it!⁷ Certainly, there are times when children and adults alike have to recognize the hurt they have caused others and learn to experience and cope with guilt; and there are times when adults have to point this out to their children. However, some people actually try to induce guilt in others, to make them do what they want them to do. For example, they might say to a lover, ‘If you leave me I couldn’t cope without you’, or even ‘I will kill myself’! They try to shift responsibility to others. This tactic may work to a degree, but you always run a risk here. If you are a guilt-inducer and go around telling people how bad they make you feel, or try to control them by inducing guilt and making them feel sorry for you (or bad about themselves), you will run into problems. You may end up with resentful others around you.

Again, one has to be honest here. Think of the last time you had a conflict. Did you say things you (secretly) hoped would make the other person feel guilty or ashamed? Even if you were successful, how would this help them feel closer to you or more keen to be with you? Think of people you know who make you feel guilty. Do you like being around them? Do you like being around people who make you feel sorry for them? Sadly, no. In the next two chapters we will look at dealing with conflicts and how to be assertive. Recognize your guilt-inducing tactics (which we all use from time to time). Once you are aware of them, then you can choose to be different and find new ways of sorting out your differences and conflicts with others.

Distancing oneself from guilt-inducers

Annie found that every time she got off the phone after talking to her mother she felt depressed. As we unpacked this mood change we found two other feelings: guilt and anger. Her mother had a knack of making Annie feel guilty (e.g., for not visiting enough), and always wanted to pour out her woes, with the expectation that Annie should do more for her. Annie felt angry at not being able to stand up to her mother. Despite this, she kept phoning, because she thought she ought to and felt guilty if she didn’t; and so she kept stirring up low moods.

I suggested a ban on phone calls (I had to take the responsibility for this at first). Second, we looked at what was a reasonable level of responsibility and what was not.

Annie acknowledged that her mother had always been like this and had alienated other members of the family too. Third, we discovered that Annie had a secret hope that one day her mother would change and give her the love and approval she wanted as a daughter. Accepting that this was unlikely was painful. Fourth, and later on, we helped Annie monitor her thoughts very carefully as she spoke to her mother on the phone, and to generate alternatives as they happened. During the conversation, she held a flash card on which she had written thoughts like:

I know Mum will try to make me feel guilty, but then she always has and she does it to others too. It's not me, it's her style. She is not going to give me the approval I want, so there is no point in secretly hoping and then getting angry. I don't have to feel responsible for her happiness, and in truth there is not a lot that I could do.

The key idea was helping Annie to keep a balance and break up her guilt–anger cycle. Sometimes it is important to keep our distance, and acknowledge that while we may feel guilty about this, we can tolerate it if we don't engage in excessive self-attacking or tell ourselves things like: 'I am bad or unlovable for keeping my distance.' And, of course, it can help to talk to sympathetic others or therapists if there are complex conflicts with guilt-inducers that you'd like to resolve.

Tolerating guilt

Carol's story, described on page 416, warns us about the un intentional dishonesty that can creep into our lives if we don't face up to our guilt feelings and simply act on them. Our feelings, such as anxiety, anger, jealousy, shame or guilt, are there because evolution has designed them that way. But we need to understand them, not just act them out. If every time we felt anxious we ran away, we'd soon end up with serious problems of managing our lives. If every time we felt angry we lashed out at people, we would not have any friends. With guilt as with so many other areas of life, it is often a matter of learning to cope with and tolerate our feelings. Indeed, if we can't tolerate at least a little guilt or shame, we will run into problems. If, in every conflict that produces guilt, we back down, we will soon feel overwhelmed and paralyzed. Sometimes therapy is about learning to tolerate our guilt feelings without becoming submissive!

There are some depressed people who are, in effect, intolerant of shame and guilt. They may feel these things acutely, but instead of working with the feelings, understanding them and learning how to accept them as part of life, they will do everything they can to turn them off and avoid feeling them. There are many reasons for this. Sometimes it is because these feelings have been over -whelming in childhood and they have not had the opportunities to work with them and accept them. And of course sometimes it is because these negative feelings trigger terrible (shame) attacks on the self in the form of self-criticisms and put-downs.

Anger and guilt

Usually, guilt does not involve anger at others. (This is another aspect that distinguishes it from shame and humiliation.) Sometimes people feel angry if they

can't own up to their feelings of guilt and recognize that they may have hurt someone. Consider an example. Tom forgets Jane's birthday and when he gets home she's clearly upset about it. Here is a guilt scene:

Jane: Tom, it's my birthday and you forgot. I feel really upset about it.

Tom: Oh, Jane, I am so sorry. You are right. I was so busy. It was really thoughtless of me. Let me put it right by taking you out tonight.

Let's assume that Jane accepts the apology and the offer. Here Tom has acknowledged his guilt (at having hurt Jane), apologized and made an offer to 'put things right'. Jane, for her part, is not intent on punishing Tom but accepts and forgives. Obviously how he conveys his genuine feelings is important here.

But suppose it went like this:.

Jane: Tom, it's my birthday and you forgot. I feel really upset about it.

Tom: Oh, come on, Jane, you know I have been so busy. I can't remember everything, I'm stressed out right now. (Angrily) Look, I am sorry, okay!

In this scenario Tom can't cope with his guilt and feeling bad, so he turns it around and blames Jane, asking her (angrily) to accept the fact that his work took precedence over her. His 'sorry' is not a 'sorry' at all. The evening will now be affected by bad feelings, because Tom does not deal with his guilt but tries to cover it up. Many therapists would see this as turning guilt into shame, but it is also a form of guilt intolerance.

Another possibility is:

Jane: Tom, it's my birthday and you forgot. I feel really upset about it.

Tom: Oh, Jane, I am so sorry. You are right. I was so busy. It was really thoughtless of me. Let me put it right by taking you out tonight.

Jane: Well, it's too late for that. I think you are a mean, thoughtless sod.

In this scenario Jane does not accept the apology. Perhaps she thinks, 'If he loved me he would not forget', and acts on that assumption, maybe also withdrawing and sulking. She is intent on wounding Tom – inducing shame and guilt. This will get neither of them anywhere.

The point here is that because guilt often arises from conflict there is always the possibility either that the guilty person won't face up to it or that the one who feels hurt will escalate the situation into yet more hurtful conflicts. As a rule of thumb, when you hurt people with your thoughtlessness – and you will, we are not perfect – own up to it. This does not make you a bad person; far from it. It keeps you in touch with your caring feelings and compassion.

If you do feel sorry for your poor behavior, then it is useful to express this as sadness rather than as anger. If you express your apology in an angry, dismissive or cold way, people won't believe it's genuine. Many apologies fall flat because of the way they are given. As a general rule, if someone who has hurt you appears to be genuinely sorry, then it is helpful to accept it. Attacking them further is usually not productive.

Guilt and forgiveness

Among the ideas that can help you with guilt over things you have done in the past are those of forgiveness and acceptance. Forgiveness is discussed more fully in Chapter 20, but we can note here that inner forgiveness can be an important aspect of change. We could all benefit from the practice of self-forgiveness because we can all look back and cringe at some of the unkind things we have done.

Kieran had walked out on his family 15 years earlier. As he grew older and matured, he was haunted by terrible guilt at what he'd done, but he could not face it; so he drank. It took him some time to recognize that when he married he was not emotionally mature enough to cope with a young family. So he had to face up to and grieve for the pain he had caused. Until he could confront this grief, sorrow and guilt, he could not come to terms with his life. His guilt had turned to shame, which paralyzed all good feelings about himself. He saw himself as a worthless inadequate who always let people down and who could never be trusted. Thus (he believed) he'd never be able to have a loving relationship. This kind of self-battery did him no good at all; nor did it help him to relate to others or to develop a more supportive relationship with his ex-wife and son, which he wanted to do. The self-battering was doing his wife and children no good either – of course the key thing was not to become so self-focused and absorbed but think how to help and repair things. Some self-forgiveness is needed. The steps to self-forgiveness often require us to fully acknowledge what we have done, face our guilt and pain and sorrow, learn from it, make amends if we can, and *give up attacking* ourselves. Here are some ideas:

- Recognize the behaviors (or whatever) you regret and be honest about them.
- Check out your thoughts and see if they are reasonable or if you are experiencing more guilt than is appropriate (see pages 283–8).
- Acknowledge that it is painful to own up to having done hurtful things to others, but that is a part of healing. There may be grieving to do.
- Focus on your behavior or the specific thing rather than turning it into a self-focused shaming experience (the 'Oh, I am bad' focus) – that is turning away from the other and in on yourself.
- Recognize that your self-criticism might be stopping you from moving forward and really facing this emotion work – so see shame-focused self-blaming as unhelpful here.
- Recognize you are a fallible human being – all of us can do things we later regret, or grow and mature and look back with sadness – feel part of the struggles of humanity.
- Do what you can to repair the harm you have done.
- Decide how you will learn from this experience and how it has 'matured you' as a person.
- Be prepared that truly facing our 'guilts' can be very 'sadness-inducing' and we might need to bear that sorrow.
- Practise compassion focusing for yourself.
- Be open to forgiveness, rather than thinking that you do not deserve it – see forgiveness as a healing process.
- Think about how by facing your guilt you are developing moral courage and trying to ensure better behavior in the future.
- Remember your essence is your consciousness that can experience many things (see page 21).
- Be clear that forgiving yourself is not about letting yourself off the hook or saying things do not matter. Self-forgiveness can be emotionally pretty tough at times because it requires our honesty and true recognition that we can be unkind.

KEY POINTS

- Guilt is a natural part of life. We can't go through life, with all its conflicts and difficulties, without feeling it. Guilt helps us to recognize our hurtful behavior. However, if it gets out of balance, it can be rather inhibiting to us in recognizing our own needs and may distort our relationships.
- Guilt often arises when we think have been hurtful to others, we haven't done enough for people, have had

to say no to people, have got more than them or have to separate from them.

- We can learn to identify our guilt areas and clarify our typical thoughts and feelings.
- Especially important is when feelings of guilt trigger self-attacking (shame-related) thoughts and feelings.
- Sometimes we need to learn how to tolerate guilt feelings, and the sorrow associated with them, as part of life (like anxiety or anger), rather than trying never to feel them.
- If you feel guilty about being depressed, letting others down or being a burden, then remember that you would prefer not to be depressed – you are not a joyful depressive! If you feel suicidal for being a burden, then be clear: this is the depression talking – and seek professional help. You owe it to yourself to do what you can to recover from your depression rather than let it dictate your actions.
- Guilt is like any other emotion. For example take anxiety; sometimes it is important to heed anxiety and run away but sometimes it is better to tolerate anxiety and stay with something that is making us anxious. If we run every time we feel anxious we will miss out on many important things in life. It's the same with guilt. If we give in every time we feel guilty this is not always helpful. Indeed sometimes tolerating guilt and not giving in is a kind thing to do.

EXERCISES

Exercise 1: Identify your key guilt areas

- I feel guilty when I _____
- I would feel guilty if I were to _____

Guilt can be helpful or harmful, so let's think about this. Clarify if it is mainly guilt you are feeling, or shame. In what ways does acknowledging your guilt and working with it help you? You might think, for example, 'It allows me to recognize when I am hurtful to others, to face up to this honestly and make reparations if I need to. This is part of growing and accepting myself as a fallible human being.'

I am sure you can think of a lot of the good reasons why we should act out our guilt and be kind to others. However, we have much to balance here because, just as it is not always helpful to run away if we feel anxious, so it is not always helpful to act on guilt and just give in or apologize when the actual problem was due to many factors and shared responsibility (see pages 284–6). To balance our thoughts, in what ways does your guilt and acting out of (i.e. without thinking too much – just doing what your guilt feeling pushes you to do) not help you?

Exercise 2: What are the disadvantages and downsides of acting out of guilt?

Here are a few:

- By always giving in to others (e.g., to a child) I might spoil them and make them selfish and expecting others to meet every need.
- I might not be fully honest with others and this can lead to problems
- I might not learn how to negotiate my needs with others.
- If guilt always stops me I might not be able to see what my reasonable needs are or learn to be assertive.
- Doing things out of guilt can lead to resentment.
- If I turn my guilt in on myself I will feel shame and then more depressed.

So, when you feel guilty it can be helpful if you face it. But you can ask yourself the following questions:

- Am I trying too hard to be nice? If so, what am I trying to achieve by this?
- Am I taking too much responsibility for other people?
- Am I able to be assertive when I need to be, even if others may not be happy with that?
- Am I telling myself guilt is always bad (all-or-nothing thinking)?
- Am I trying to avoid painful dilemmas by not feeling guilty?
- Do I feel guilty if I succeed when others fail, and if so, does this hold me back with no real benefit to anyone?
- Do my difficulties with guilt block my growing?

Exercise 3: Some ideas for facing guilt

You can refocus on a compassionate approach by taking a few soothing breaths and switching to your compassionate self (see pages 149–55). With as much kindness and gentleness as you can muster consider the following:

- Guilt feelings are part of life – there is nothing wrong about me feeling them so I can learn to tolerate them with kindness.
- If I could tolerate my guilt feelings without acting on them, how might this help me improve things in my life? (Spend some time thinking this through.)
- If there are indeed grounds for guilt, what would be helpful and compassionate for me to do?
- If I'm honest, are other people really expecting too much of me?
- In fairness, am I expecting too much of myself?

- What would I say to a friend in a similar situation?
- Do I need to learn the process of self-forgiveness?

Exercise 4: A life review

Writing a life review can sometimes be useful. Start by writing: 'I have learned to feel guilty because.' Then, just for yourself, write your own story of how you think this may have happened. Then write, 'The challenge for me now to move forward on this problem is to.' You might also consider writing some compassionate letters to yourself (see pages 233–9).

Coping with anger

Strong feelings of anger are common in depression. Freud believed that unexpressed anger actually causes depression, as if anger can be turned inwards. He thought that people are angry with themselves to avoid being angry at others on whom they may depend. As we saw in our chapter on self-criticism, there can be a lot of self-directed anger and frustration in depression. However, we now know that, in some depressions, people become more angry and short-tempered with others, not less. In some of our own research we found women become angrier with themselves as they become depressed but men become angrier with themselves and others.¹ When we feel angry and on a short fuse it is often those weaker than ourselves that get it.² People can also be very fearful of their anger.³

There are four domains of coping:

- the anger that others direct at you.
- the anger you (want to) direct at them.
- the anger you see others directing at each other (e.g., children watching their parents fighting).
- the anger you direct and feel for yourself.

What triggers anger?

Anger is often related to feeling frustrated, blocked, thwarted, ignored or criticized. Something or someone is not as we want it or them to be. In evolutionary terms, anger gives us the energy to overcome the blocks to our goals, or to fight harder (counterattack) in a conflict situation. Thus, anger can be a natural response, although unpleasant and undesirable.

Examples of some of these are threats, damage or losses to:

- our sense of self (be this physical or self-esteem)
- relationships and possessions that are important to us
- our plans and goals
- our way of life.

Obviously our sense of control is important here, and anger can be a way to try to regain control. It can rise quickly in us before we have much chance to think about it – thus the value of practising mindfulness.

Frustration

Frustrative anger occurs when things in the world don't go as we want them to – e.g., the car won't start in the morning so we can't get to work on time. Stress and depression can lower our tolerance for frustration and thus increase our susceptibility to feel anger. When stressed, we may feel generally more vulnerable to things that can damage or block us, and there are also some basic self-beliefs that can affect our tolerance for frustration – for instance, 'This shouldn't happen to me', 'This is going to seriously interfere with or block me in what I want to do'. Time pressures and things going wrong unexpectedly can lead to the familiar flush of irritable anger. Don't I know that one! However, people who are going to be able to cope with such things as the car not starting will note the flush of anger, and then quickly turn to coping (e.g., get a taxi). Those of us who struggle will personalize and may feel 'let down by the car' (how could you do this now!) and have a tantrum.

Coping then is making a commitment to try to cope with your anger in the following ways:

- Note the flush of anger as it arises in you.
- Break your focus (e.g., by switching to soothing breathing).
- Hear that kind voice of understanding in your mind.
- Recognize that anger is a perfectly understandable feeling (don't self-blame and start battling with yourself), but is not helpful in this moment.
- Keep in mind that it is not personal – it happens to other people too.

Really focus on coping and *what is going to be helpful to you right now*; for example, do you need to take yourself away from the situation (or person) until you are calmer; do you need to seek help?

Injury

We can feel anger when others pose a threat to us or injure us in some way. Physical or verbal attacks can lead to feelings of anger. Anger is likely to be greater if we think the injury was deliberate, or the result of carelessness, than if we think it was unintentional or unavoidable. The anger that we feel towards an intentional injury can be revenge, and the impulse is to harm (counter-attack) the other person verbally or physically. These feelings are common in group conflict and war. Even when people rationally realize that cycles of vengeance are doing no one any good, it can be hard to stop. Coping is similar to the above: noticing anger arising and then shifting attention, and making clear in one's mind that anger is not a good place to be acting or thinking from – don't forget that this takes practice though, so go easy on yourself but try your best.

Exploitation

A very common theme in anger is exploitation. This is when we think someone is taking advantage, using us or taking us for granted. As we have seen, most of us have a desire to feel appreciated and for relationships to be equitable. Be it in child-parent relationships, between friends and lovers, or even between countries, perceptions of being exploited or taken advantage of can lead to anger and its consequences.

Assertiveness and dealing with the issue at hand are often important.

Lack of attention

Anger can arise when others don't give us the attention we want. They may ignore us or dismiss our point of view. For example, Emma wants Chris to spend more time with her and help around the house, but he says that he's too busy. Or maybe Chris says he will help but does not keep his promise. Emma feels angry with Chris. However, with this kind of anger, we rarely want to harm the other person, but rather behave (e.g., scream and shout) so that they don't ignore us. We want to renegotiate our relationship, not necessarily destroy it. Sometimes this requires a steady and constant compassionate addressing of the issues.

Envy and jealousy

This kind of anger arises when we think that someone is getting more of something desirable than we are. Linda thought that she would win the beauty contest, but she didn't, and she felt envious anger towards the winner. In envy, we want what someone else has, be this material possessions, a position in society, a popular personality, intelligence and so on. In jealousy, we think that someone we value might prefer to be with a person other than ourselves – for example, a married woman shows an interest in another man and her husband has pangs of jealousy. This type of jealous anger (if expressed) acts as a threat to the woman, suggesting serious consequences if she were to cheat on or leave her husband. Sexual jealousy is more likely to arise for someone who sees their lover or partner as a possession. Jealous people can also be very insecure and may come from backgrounds of sibling rivalry or having to 'battle' to win parental attention.

Lack of social conformity

This anger relates to the feeling that others should do as they are told. Parents become angry with children who disobey them. A religious person becomes angry if the members of his church do not obey the rules. We may become angry with our government over how they spend our money. The basic belief here is, 'Others should conform to and obey the rules of conduct that I believe are important'. The anger occurs because, in some way, we see the other person's conduct as potentially damaging to our own interests or way of life.

Sympathetic anger

This is when we feel angry by seeing harm come to someone else – for instance, when we see people starving and feel angry that this has been allowed to happen. The anger fuels the desire for us or others to do something.

The helpful and the unhelpful

There are two aspects common to all these situations: first, things are not as we want them to be; and second, we place a high value on the things that we are angry about. In helping ourselves with our anger, it is possible that we may discover that we are

overvaluing something, drawing conclusions about a situation that may not be warranted or seeing more potential damage in a situation than there is. Anger can be *very helpful* because it alerts us to things that we need to defend or change. People can be inspired by anger (at, say, injustice) to change things, or to have their voices heard. It is usually when anger involves ill-will or desires to cause harm that we have problems – and of course this ill-will can be directed at oneself.

The shades of anger

Anger itself is not all-or-nothing, black or white – it is more shades of pink to red. For example, imagine a line that starts off white and gradually becomes pinker until the other end is red. At the white end, there is no feeling at all, nothing matters. At the other end, one is enraged. The trick is to be somewhere along this line where you can keep control, but not in the white area or the red area. Anger is like a car that we need to learn how to drive. You don't want to drive everywhere at 100 miles an hour, but neither do you want to leave the car locked in the garage because you are frightened of driving.

Sometimes depressed people do not know how to drive their anger. They continually lock it up and enter only as far as the vaguely pink area – at least as far as expressing their anger goes. This may work if you are confident in doing that and don't need to show your anger. But it is not so good if you do need to reveal it and feel weak and inferior if you back down too quickly. If you feel that your anger tends to get out of control, you can learn other strategies. Here are some to think about.

- Learn to become more aware of anger arising in you, and your trigger points.
- Recognize when you feel your anger is more in control than you are.
Note that this is not your fault, but you need space not to let the sparks of anger get fuelled by your thinking or behavior – so learn containing skills such as:
- Learn to break contact with others if anger is too hot. 'Look, I'm going for a walk as I need to calm down a bit – sort my head out.'
- Practise being compassionate to your anger (not self-critical or condemning) while practising your anger coping skills as best you can.
- Practise switching your attention to your breathing or compassionate self or image.
- Not matter how silly or difficult it feels, create a compassionate smile on your face.
- When you are able, explore your thoughts and see if you can bring more balance to them.
- Avoid self-blame, condemning and self-retribution.

Anger is often defensive, in the sense that we are defending ourselves against a block to something or from criticism or being ignored or dismissed. When we behave defensively we often go for 'better safe than sorry' thinking, and our emotions are triggered quickly (see Chapter 2). This is why many psychologists think that beneath the veneer of our anger we feel vulnerable – not someone who is confident or strong.

Why anger expands

Why can anger feel so powerful? Why does it hit the red zone? It is not uncommon to find that what triggers anger can seem quite trivial. We might suddenly find that we

are seething with anger over rather small events. It appears as if our anger has expanded. In some depressions, there are 'anger attacks', when people find themselves enraged for reasons they can't put their finger on. Some researchers believe that, in some cases, anger attacks are to do with the depression itself (and the biological changes associated with it). Some people on certain anti-depressant drugs can experience increases in irritability – for others they are more calming. If you find that you have become far more irritable and angry since starting an antidepressant, go back to your family doctor, who may recommend a change in medication.

There are also psychological reasons for 'blowing up' over a trivial event. Let's think about the example of Emma and Chris given on page 444. Suppose Emma says to herself, 'If Chris really cared about me, he would help with the housework'. Clearly the anger is not just about the housework but about the fact that Chris's lack of help is being taken as a lack of caring. Emma may also feel taken for granted. Thus, what seems like a trivial event actually has a much larger meaning.

When you think about the things that make you angry, it is useful to ask yourself some questions – invite your anger to speak to you, as it were. Okay, anger, now . . .

- What is it about this situation *that I really* value and feel could be damaged?
- Let's suppose I cannot change the situation. What does this say about my future.
- What am I saying about me if this (the source of the anger) happens? Am I drawing negative conclusions about myself?
- What am I saying about the other person? What motives am I reading into their action?

Another question that can be very useful is to ask is, 'In what way does this situation hurt me?' In depression, as a rule, it can be helpful to focus on the feelings of hurt rather than on the anger. If we focus on the anger, we could miss the fact that it relates to feeling vulnerable or damaged in some way. Indeed, by being angry we can sometimes block out deep fears of being abandoned, ignored and hurt. Behind anger in depression can be a lot of hurt, a need to grieve for past hurts and problems of shame. If we can work through the grief, the anger and the depression may subside.

If we focus on our hurts rather than on our anger, we might gain more insight into our anger. In Emma's case (see page 444), she saw that she believed that Chris's lack of help had the extra meaning of 'not being cared for', which led to the idea that maybe he did not value her or thought she was not worth caring for, which led to the idea that maybe he was right. This sensitivity may be from the past (e.g., feeling parents or friends did not care enough) but the key is that when Emma reflected compassionately she worked this out for herself. She realized that caring was not 'all-or-nothing' and that there were in fact many other instances that showed that Chris did care.

So our anger can expand when we overestimate the damage that can be done to us. Here's another example. Derek was working on a project that required help from others. However, they did not finish their own work on time and he became furious. His thoughts were, 'If I don't get this project in on time, that will be a very bad mark against me'. He had a fear of being seen as inadequate by his boss. 'They are making me look incompetent to my boss. This could affect my chances of promotion. Therefore, these people, by not doing their work on time, are shaming me and ruining my whole future.'

When Derek focused on his own fear of shame, he began to see that he often got angry with anyone who might ‘show him up’. This led him to consider why the approval of those in authority (mostly men) mattered so much to him. This in turn revealed the poor relationship he had had with his father and his belief that, ‘I must please those in authority, otherwise they will be angry and ignore/discount me’. These thoughts ignited many of the feelings and fears he had as a child. His anger was powerful because of the meanings he put on the situations that triggered it. Later, Derek was also able to see that his belief that ‘his whole future would be ruined’ led to a high degree of anger.

Derek learned to deal with his anger by making a number of flash cards:

- When I feel anger, I need to slow down and monitor my thoughts.
- If I don’t slow down and monitor my thoughts, I am likely to see many events as a re-run of my childhood.
- When I get angry, I often overestimate the damage that can be done to me.
- What is the evidence that this situation is damaging? How can I cope with it by getting less angry?
- I don’t have to feel ashamed by every block or setback.

Having the flash cards gave Derek that extra bit of space to avoid letting his anger run away with him. It helped him to take his foot off the accelerator. It’s not magic but it is a help. You might want to write some out for yourself like Derek’s.

Robert became enraged when he went to a hotel and found that he had been put in the wrong room and the young receptionist didn’t seem to care. He ended up telling her that he didn’t think the hotel should employ people like her. When he got to his room, he felt ashamed and depressed about his over reaction, sat on his bed and burst into tears. What had happened here? Later in therapy he was able to work out his thoughts as the following:

- Why can’t people get things right?
- This receptionist obviously sees me as a fool and a soft touch.
- If I were manly, I would sort this out without any difficulties.
- People should respect me and not treat me this way.
- I must be seen as a weak, useless bastard.
- That’s not fair – I’ll show her that I’m somebody to be reckoned with.

Of course the anger is more of a rapid ‘whoosh’ than built up thought by thought – but the thoughts show us what is in the anger. In a few seconds the problem had grown out of all proportion and had become a question of respect, manhood and being seen as a soft touch. The receptionist’s attitude had triggered Robert’s underlying fear of being someone not worthy of respect and of his sense of inferiority – all of which he defended with rage.

Later, while still sitting on the bed, he recognized that he had behaved aggressively to the receptionist. He then thought:

- I’m losing control.
- What’s happened to me? I used to be caring of others.
- Maybe I’m just a selfish person who has to have his own way.
- I am unlovable and bad for being like this. I hate myself for being like this.

So we can see how Robert's anger expanded because he had overestimated the damage to his self-esteem and had believed that this was a test of his manhood. In fact, it is not uncommon to find that depressed people can have rages and then feel intensely unlovable and hate themselves for it – they feel angry with themselves for being angry.

George became enraged with another driver while driving with his family. His children were frightened and started to cry so he screamed at them, too. Later, he felt ashamed and guilty. He thought that he had ruined their day and was a horrible man to 'go off like that'. At 3 a.m., feeling alone and unlovable, he started to think that they would be better off without him and contemplated suicide. George's anger was a sign that he was not coping and was feeling very vulnerable underneath the rage. He was in a depressed brain state, where anger is far more easy to activate. When things are tough like this, it is the very time to be gentle with ourselves. Indeed, the tougher things are, the more powerful compassion can be. Being kind to ourselves for being a little upset is one thing, but if we can be compassionate when we have a rage then that is powerful. Remember, this is not 'letting ourselves off the hook'. Indeed, sometimes we will feel *more* upset at the upset we have caused others when we give up self-blame and focusing on ourselves. We are kind because we mean to heal ourselves, and make genuine amends for any hurt we have caused.

So, understanding the values you place on the things that make you angry is a first step. Then consider the ways that you feel hurt and vulnerable. If you sometimes feel that you lose control, avoid globally attacking yourself and instead look for alternatives. The following are the ones that Robert eventually came up with for himself:

- Okay, I did go off the deep end and that is disappointing.
- However, I know that I'm not always or even usually like this.
- I need to recognize that I'm under stress right now and that my life is not easy, so my frustration tolerance is low.
- I need to learn to back off when my feelings are hitting the red zone. However, a low frustration tolerance does not make me a bad person – even if some of my actions are undesirable.
- I will help myself if I learn to be more assertive rather than aggressive. If I label myself as bad, I will only feel much worse, and when I feel bad and ashamed of myself, my frustration tolerance level goes down further.
- I can forgive myself for this, apologize to the hotel assistant if I need to and move on. Hating myself is failing to treat myself with compassion and recognize the stress I'm under. If I treat myself better, I'm more likely to treat others better.

You may have noted that the anger in the various examples outlined above could also be seen as 'shame anger'. The anger acts as a defensive measure against being put down, feeling small, discounted or rejected. Indeed, in situations when you feel anger, it is always worth thinking that shame may be part of your feelings. You can get into shame/anger spirals where you are angry at being shamed and ashamed of being angry. The first step to get out of this is to avoid attacking yourself (see Chapter 13).

Shoulds and oughts

One reason why we can feel anger is when we are using ‘shoulds and oughts’. Robert, in the example above, had thought, ‘Others *should* not behave this way’. Unfortunately, we can’t write the rules for how other people will behave. If we are not careful, we can get stuck and simply go over and over in our minds what another person should or shouldn’t do. A couple of times I have noticed my anger arising in airport queues, and my thoughts of, ‘These queues are ridiculous, it’s sheer incompetence; no one cares; they treat us like cattle’ and so on. I don’t like being trapped in queues – it’s rather claustrophobic – so that fear can fuel my anger. Of course my anger does no good to anyone, and certainly not me or my blood pressure. I have to try to switch attention to the soothing breathing, create the compassionate smile, note how others are caught here too – it is not personal. One notices the anger and then *makes the choice* to try to refocus one’s mind on helpful thinking *for one’s own good*. At times, ‘shoulds’ are related to other thoughts, such as ‘If X loved/respected me, he/she should/shouldn’t’. You can work on these ideas by telling yourself:

- I would prefer that others did not do this.
- However, I cannot write the rules for their conduct.
- Each person is free to behave in their own way.
- If I don’t like the way they are behaving towards me, I can learn to be assertive and put my point of view.
- I do not have to personalize every conflict situation and see it as a personal attack on my worth, selfhood, manhood or whatever.

Who is to blame?

In depression people frequently feel bad about themselves for getting angry. How can you treat yourself kindly if you have become so angry? Again, we need help from the compassionate/rational mind. It may help us with such thoughts as:

- It is indeed upsetting to become very angry.
- It may mean that underneath I am feeling very vulnerable.
- However, my anger doesn’t make me completely unlovable as a person – that would be overgeneralizing, thinking in all-or-nothing terms and self-labelling.
- It is this particular action at this particular time that was rather harsh.
- Remember the times that I’ve been caring and not angry and how it’s possible to do positive things for myself and others.

Sometimes, if we have been angry (especially with children), we feel so guilty that we think we have to make it up to them and start to allow them to do things that we would normally not allow – because of guilt. However, this can backfire because the children, being children, might start to take advantage of the situation, which can trigger our anger again. If necessary, apologize for your action and then work on gaining more control over it rather than acting out of guilt.

Hatred

Sometimes, because we believe that we have been very hurt or damaged, anger turns to hate. Then the desire is to harm others, and this can be frightening. Bella came to hate her mother because of a very physically and emotionally abusive past. She felt that her mother had ‘an evil tongue’. She had fantasies about stuffing a pillow in her mother’s mouth and watching her choke to death. However, she was desperate to be loved, and she took her hatred and murderous thoughts as evidence that she herself was evil. Her thoughts were:

- Hatred is bad.
- I should not feel like this.
- It is abnormal; others don’t feel like this.
- I must be bad/evil for feeling hate so strongly.
- I can’t reveal to others the depth of my feelings because they will think that I am evil, too.
- I hate myself for hating.

Her doctor, who had been treating her with drugs, had no idea of this inner life. This is not surprising, for such hate-anger is often not revealed if there is strong fear or shame associated with it. Bella was able to begin to challenge these thoughts and ideas:

We all have the capacity for hatred – it is not itself abnormal. Indeed, sadly, history shows the consequences of hatred, so there have been many who have felt like me. I am not abnormal. To call my hatred ‘evil’ is all-or-nothing thinking and self-labelling, and leaves out the hurt I have felt because of what happened to me. I did not wake up one day and think that it would be a good idea to hate my mother. These feelings have come from a lot of painful experiences, and it is understandable for me to hate someone who has hurt me so much. However, I do need to learn how to work with my hatred and come to terms with it. I need to learn how not to hate myself for hating. This is because my hatred hurts me and holds me back in my efforts to get well.

Avoid brooding

Brooding and ruminating is bad for our brains (see page 28). If we think about what anger is designed to do, and recognize that one of its functions is to help us to fight harder, we can see the danger of brooding on angry thoughts.¹ These turn on our threat self-protection fight/flight system, when stress hormones and other chemicals are pumped around our bodies, which become tense and alert. However, if no ‘fight’ or ‘flight’ happens, these chemicals can get up to mischief.

Allen was asked to take early retirement, and a new manager started to undo all the changes that he had introduced in his section. He had various arguments with his boss, but all to no avail. Allen became depressed and had serious sleep difficulties. I asked him to monitor his thoughts when he woke in the middle of the night. These turned out to be: ‘The bastard. After all the years that I have worked there and this is how they treat me. There must be some way I can stop them. I can’t just roll over and let this happen.’ When these thoughts began to run through his mind, he became quite agitated and would pace about the house, going over and over them. If his wife tried to calm him down, he would snap at her and then feel guilty. Then he would say to himself, ‘They’re even breaking up my relationship with my wife’.

My discussion with him went something like this: ‘When you have these thoughts,

they activate your primitive fight/flight system and that's designed to hype you up – to fight or to run away. However, you've done what you can and there seems to be no way that fighting can help you now – especially at three in the morning. You're left in a hyped-up state that has nowhere to go except in pacing about and snapping at your wife. You've recognized that, in reality, there is not much you can do.' Allen reluctantly agreed. 'So we have to find a way for you not to activate your fight/flight system because it drives you into depression.'

As Allen came to understand the processes that he was activating in himself, he was ready to start to explore alternatives. We wrote out some flash cards for him to read if he woke early:

- I am disappointed with this situation, but I have to face the fact that I have done my best and this is the way of the future.
- I have given the company many good years, and it has not been too bad really. I can be proud of that.
- Perhaps the time has come to let go and think about the next phase of my life.
- All these thoughts of fighting and getting my own back only hype me up and to no real purpose.

We might also care to reflect on a more Buddhist or philosophical view that all things are impermanent, nothing stays the same; the sea continually moves and if we try to stop things changing then we are on to a loser. Sometimes letting go (and grieving if we need to) can be one of our most important life tasks – and a tough one. With Allen we also examined the advantages and disadvantages of taking early retirement, including the fact that he would have more free time and that it would probably be better for his health. Once Allen let go and gave up fighting an unwinnable battle, he was free to explore other strategies – such as how to get the best deal for his retirement. It was not easy, but a year later, he told me that it had been the best decision he'd ever made.

So the key issue is to avoid brooding on anger. Work out strategies for coping. If there are things that can be done, do them. If there are others who can help you, seek their help. But brooding on injustice, going over the same ground over and over again, does not help. Giving up an unwinnable fight is one strategy, but at other times you may need to learn how to become more assertive and stand your ground (see Chapter 20).

Anger to avoid pain

Caroline was angry with her parents because she thought they did not love her enough. As long as she felt angry, she avoided the great sadness and need to grieve that were underneath her anger. Anger gave her some feelings of power. Sadness and grief made her feel very vulnerable.

Anger can be used to prevent the recognition of being hurt, but it is often hurt and shame that need healing and this often involves sadness. Some people may imply that all you need to do is to get your own back on the person who has harmed you or to stand up to them. However, although this can be helpful it is not always so. Underneath, we still have a wish to be loved and approved of. I remember a patient who had done quite a lot of work with another therapist on learning to stand up to her

abusive parent and express her anger. However, despite this, she was still depressed and mistrustful. What she had not done was grieve for her lost childhood or allow herself to feel and accept the feelings of vulnerability in grieving.

You see, there are always two parents inside us. There are feelings and memories of the one we actually had, but also the desires, fantasies and hopes for the one we wanted – that ideal protective, loving, caring parent. We can work on coming to terms with the abusive parent and our anger with them, but we also need to work on grieving and letting go of the parent that we always wanted. We can do this by using our inner images and practise becoming the compassionate self – or sometimes through new loving relationships.

In working with anger in depression (and I stress ‘*anger in depression*’ because not all anger is like this), it is sometimes important to find someone who will help you move through the grieving process. In grief, we acknowledge our pain and vulnerability. In the grieving process itself, anger is often the first or a very early response – but we have to work through this stage rather than get stuck in it.

Bypassed anger: 10 common reasons for avoiding anger

Sometimes people try to avoid feelings of anger altogether. If you bypass anger, you might go straight to feeling hurt, but also feel a victim, a powerless subordinate. You will also bypass becoming assertive (see Chapter 20). You may feel that you have no power to do anything about certain situations. You might think that you feel hurt because you are weak, and you may not be able to focus on the fact that it is at least partly the attitude of the other person that is the cause. It is important to recognize your hurts without, at the same time, becoming a powerless victim.

Here are 10 self-beliefs that may stop you from exploring your anger and learning how to use it in an assertive way. Following each one, I offer some compassionate alternative ideas.

1: Others are more powerful than me. I will never win in conflict with them.

Compassionate alternatives: It’s not about winning and losing. Even if I don’t achieve the outcome I want, it is helpful to try to put my point of view. If I tell myself that I *have* to win, otherwise it’s pointless, I am defeating myself before I start. If I attempt to put my point of view, at least I will have tried. Trying to be assertive means that I am less likely to be angry with myself if I don’t get the outcome I want.

2: I learned in childhood that anger is bad.

Compassionate alternatives: Because my parents could not cope with my feelings of anger does not mean that anger is bad. Anger is part of human nature, and it can be useful. If we never felt angry about things, would we be motivated to change anything? Anger is really important because it reveals where I am hurting and what I value. True, aggression and lashing out are not good, but anger turned to assertiveness has many uses. Although my parents taught me that anger is bad, they may not have taught me how to be assertive. Perhaps they did not give me any

positive ways to deal with conflicts – maybe the problem was that they did not know themselves. I need to learn this for myself.

3: When I am angry, I am bad and unlovable.

Compassionate alternatives: Of course, I might prefer never to be angry but that's not possible. In that moment, feelings of love might not be there, but that is like a storm that comes and goes and meanwhile the sky remains itself. To say that I am unlovable is all-or-nothing thinking and self-labelling and discounts the positive aspects of my life. When I think of being unlovable, I may be thinking of being unlovable *to someone*. Who is the person I feel unlovable to? If it is my partner, I can think of it this way: relationships are like boats. If my boat can only sail in a calm bay, it is not much of a boat. We need boats that will not capsize even if a storm blows up. If I see myself as unlovable when I feel angry, I am also saying that my relationship can't cope with the odd storm – but, in fact, clearing the air and being honest and frank with my partner is likely to strengthen my relationship, not ruin it.

Of course, it is true that, at the moments of conflict, you are not sharing loving feelings, but love is like the climate; it remains no matter what we do. Anger and conflicts are like wind and rain – they come and go. Just as one thunderstorm does not change a climate, so your anger does not make you unlovable. You can learn to survive conflict.

4: When I am angry, I am being disloyal.

Compassionate alternatives: Blind loyalty is rarely helpful and it is better to develop openness and respect. If I am respectful then I am also honest – because one can't be respectful in being dishonest about one's feelings. To feel disloyal is linked to guilt (see Chapter 18) but this does not mean I do not care for the other person. I also need to think if I am actually worried about being rejected for rebelling! Sometimes, when I confide in people I trust – about the anger I feel towards others close to me – I can have strong feelings of being 'disloyal'. However, confiding in others might help me to get my anger in perspective. If the person I am angry with has done things that have hurt me, keeping them hidden is really colluding in a secret rather than showing loyalty. I confide in others because I want to sort out my feelings. It is understandably difficult if I feel that I am 'breaking loyalties'. However, remember that people have done all kinds of bad things out of loyalty. If I show compassion, I can try to change things in a different way.

5: I must not hurt others.

Compassionate alternatives: Deliberately hurting others is not, by most people's standards, a moral thing to do, but the anger we are talking about here is not like that. Rather, I want to use my anger to draw attention to the fact that something is causing me pain or hurt, and change it. I have no wish to harm others just for the sake of it, but to help them see how they are hurting me and to stop them doing it. In this sense, my anger is defensive. Others are far less likely to be hurt if I explain my position and show respect for them rather than attacking them. It is also the case that I can't be held responsible for everyone's feelings – that's giving myself too much power. In any case, I might, in the long run, be more hurtful to them and our relationship if I

am not honest with them about my feelings. Think in terms of respectful rather than hurting anger. This is not an excuse to act out whatever emotions I fancy – I will try to be emotionally polite as well as honest – thus as with all things it is a matter of balance.

6: I can't stand the feelings of anger.

Compassionate alternatives: Angry feelings can be frightening if I am not used to feeling them. I may block my angry feelings if I feel that I might lose control. However, I am far less likely to do this if I learn how to be assertive (see Chapter 16). Learning how to mindfully 'be with' my anger and learn acceptance and tolerance means that it will no longer frighten me and that will help me greatly.

7: I might lose control and damage people.

Compassionate alternatives: It is my responsibility not to do that. So I need to consider a number of things. First, am I seeing my anger as more damaging than it is? Am I secretly telling myself that I am a very powerful person and that everyone around is so fragile that they could not possibly cope with my anger? If so, I can try to think of the reasons why I might wish to believe that. Then work out the evidence for this belief and the evidence against it. Lashing out at people – going into the red zone – is not a good idea, but this is no reason to avoid being assertive with others. Let me think about times I have been angry but in control. Let me make a commitment to myself to stay in control but not in a way that simply silences me. Like driving a fast car, I can learn to drive at different speeds as are appropriate – I have just got to give myself a chance to learn. If I do go OTT and say hurtful things then I need to be honest about that, recognize my fallibility, also apologize and try to repair the harm I have done (see Chapter 18).

8: I might lose control and make a fool of myself.

Compassionate alternatives: It may be that I am prone to feeling shame if I express my feelings, so I can work on that. It may also be true that if I become very angry, I might say things that I do not mean or become tongue-tied. The main thing is to try to focus on the issue, that is the message I want to convey, rather than my anger.

If you have become angry, find out if you are having self-critical thoughts and calling yourself names (e.g., 'I'm stupid,' 'I'm a fool'). If so, recognize this is all-or-nothing thinking and discounting the positive aspects of your life. It would be helpful to remind yourself that your anger is one element that you might wish to change, but it does not make you a fool or stupid. We can all do and say foolish things from time to time – but we can also learn to tolerate and forgive ourselves for them.

9: I only feel I have a right to be angry if I am 100 per cent sure that I am in the right.

Compassionate alternatives: There are few things in life where one can be 100 per cent right. This is all-or-nothing thinking. Maybe no one is right or wrong, but everyone has a different point of view. Sharing these differences can be a source of growth. In any case my anger cannot be stopped simply by saying I have a right or I

don't. I can also keep in mind that even if I feel I have a right to be angry, it does not mean anger is a useful response – sometimes forgiveness is.

10: I would be ungrateful or selfish to show anger.

Compassionate alternatives: 'Selfish' is, of course, a self-label and I am probably discounting all those times when I have given of myself. Even if I feel grateful to someone, this does not mean that there cannot be disagreements between us. I can show gratitude when the situation warrants it, but positive things can be achieved in not hiding my discontent.

Be cautious not to let your gratitude turn into a trap of obligation, for then you may feel more resentful.

Acknowledge if your anger is upsetting to others

Not so long ago when I was a stressed and my father had just died, I lost my temper big time with my computer at home which had suddenly decided it wasn't going to receive any e-mails or save files. I was under time pressure to get to work. In my explosion I said some very naughty words and threatened to completely kill, destroy and smash my poor computer that had been working well for years. Hearing this explosion of rage was of course very upsetting for my wife. Then I rushed out of the house and drove off far too fast – again, rather upsetting for my wife. A mile down the road that little voice kicked in, 'Gilbert you asshole! You are not supposed to get angry like that. Good grief – and you're writing a chapter on anger too – it was very upsetting to Jean – how could you!' However, thanks to my practice I think, I found there was a compassionate voice which soon recognized that I was actually quite distressed and simply said, 'You're very distressed right now, it's not your fault (and that felt sad then), but do pull into the side of the road, phone Jean and apologize and let her know you are okay.' So I did, and felt better. The point of the story is that it helps if we can quickly go to the compassionate self as anger arises in us and then behave as best we can. It is not easy, but if you're kind to yourself and own up to hurt if you have caused it, this will help you.

Overview

Anger is one of our main threat self-protective defensive emotions. It's one of our big emotions in our brain and therefore is easily aroused and can be tricky to control. This is not our fault at all, but it is important to learn how it is triggered in us and how to exert control. It might be linked to things from our past, the beliefs and attitudes about ourselves and other people we are carrying. We may use anger to avoid feelings of hurt, or to keep people away, or even to test them out.

Whatever the reasons for having difficulties with anger, and depressed people often do, the task is to be gentle with yourself about the problem and then think about how you can learn to manage your anger by either becoming more assertive or working on the things that make you angry. As with all of the ideas we are exploring together, be compassionate with your anger but at the same time do the best you can

to work with it in a helpful way.

KEY POINTS

- Anger is part of life and can be aroused in situations when we perceive actual or potential damage to something we value.
- In depression, we can become too angry and 'blow up', or we can hide our anger.
- We may resort to rather underhanded ways to avoid open conflict, get our own way or get revenge.
- Anger is very often related to shame – our greatest rages often occur in situations where we feel shamed, whether we recognize it or not.
- At times it is important to consider whether we are overestimating the amount of damage that can be, or has been, done (e.g., to self-esteem).
- Anger itself is not all-or-nothing, and it is useful to learn how to control it rather than allowing it to control us or locking it away.
- Brooding on anger leads to an aroused (hyped-up) state, which is often very unpleasant and not helpful.
- There are a number of primary self-beliefs that make anger difficult to deal with because they do not allow it to be worked through and it stays hidden.

EXERCISES

Exercise 1

Write down your thoughts about the last time you became angry. Ask yourself questions like, 'What am I saying about this event?' 'What implications am I drawing?' 'What do I think this event (or the other person's attitude) says about me?' 'What am I saying about myself?' When you have written down some of your thoughts, explore whether you are engaging in any of the following: all-or-nothing thinking, overgeneralizing, discounting the positives, thinking in 'musts' or 'shoulds', and so forth (see Appendix 2). Let's work through the example of Emma becoming angry with Chris over him not helping with the housework. The following are her main thoughts and the possible coping responses she came up with:

- I'm always left with the housework while he goes off with his friends.
Well, actually he does help sometimes. I am overgeneralizing here. And I am ignoring some of the other positive things he does to help. Still, I do feel strongly that he should do more. I need to sit down with him to talk about it – when I don't feel so angry and upset.
- This is really unfair. If he cared about me, he would help out.
Is doing housework the only sign of caring? Chris is behaving in a way that is traditional for males. His father was the same. I may not like it, but I may be exaggerating if I think this shows that he doesn't care about me. I need consistently to point out that this is a concern to me so that he can learn to change.
- He takes me for granted.
I might feel taken for granted, but is this true? What evidence is there for and against this idea of being taken for granted? It might just be thoughtlessness and the need to help him be more attentive.
- Maybe that's all I'm good for. If I was more lovable, he would be more attentive.
I recognized a problem about who does the housework. However, I'm going to feel much worse if I start to think Chris's lack of interest in housework is a lack of interest in me. It is this blaming myself and feeling unloved that is making me depressed. It could just as easily be a typical male attitude. I need to train him!

Exercise 2

If you tend to become too angry, try to spot the danger signs early. Think back to the last time you were angry.

- What was going through your mind? What were your early feelings? Was there any build-up to it? Could you spot the danger signs – feelings of getting wound up? If so, learn to say to yourself, 'I am entering my danger zone and need to back off – keep my distance'. If you find yourself getting too angry, move away from the other person. Blowing up at others is not helpful. However, if it is appropriate, come back to the issue that was behind your anger when you feel calmer. Don't avoid the issue but avoid the strong anger that might lead you to say things you later regret.
- Use the 'count to 10' approach. If you suddenly feel very angry, stop, then count to 10 slowly, then take a deep breath and change your facial expression. Learn to avoid acting when you have hit the red zone. You may also try leaving the room. The key idea is to distract yourself, and give yourself time to calm down sufficiently to stay in control.
- If any of the '10 common reasons for avoiding anger' (see pages 460–6) apply to you, make your own flash cards and try generating compassionate alternatives to these thoughts. Think of the advantages and disadvantages for changing them.
- If you are frightened of the feelings of anger, try expressing anger when you are alone. Get a rolled-up newspaper, stand by the side of your bed and hit your bed with it. As you do, speak (or shout) your thoughts about your anger. Allow yourself to feel your anger. Remind yourself that no one can be hurt by this exercise – the point of it is to help you become less fearful of the feelings of anger. When your anger has subsided, you may wish to cry. Allow yourself to do this. Then, and most importantly, before leaving

the room lie on your bed and carry out a compassionate exercise. Think to yourself, 'This anger episode is over and I will let it go'. Imagine a stormy sea that becomes calmer. The idea is to recognize that you can become angry but will also calm down. Learning how to do this is important, because it helps you avoid brooding on your anger.

- At the end of the exercise, note that you were able to become angry and to calm down afterwards – imagine your compassionate image and feel warmth and kindness for you. Remind yourself anger is a part of us that's difficult, that's why we have compassion for it (we don't need compassion for things that are easy!). Over time, you may learn that the feelings of anger themselves need not be frightening, even though they may not be pleasant. But you were able to control your anger by directing it at the bed. This exercise is not designed simply to release anger but to allow you to experience it without fear. Go step by step, and learn that, even when you are very angry, you can still stay in control of your feelings. This is to help you become less frightened of your anger but it does not ignore the issue that you may need to explore what is causing your anger. Is it possible you're getting to boiling point because you find it difficult to be assertive in small ways?
- When you feel calmer, write down what you said when you were angry – what went through your mind? Explore to see if some of your thoughts were extreme and should be challenged. The next stage may be to recognize where you are hurting and what your anger is about. Then use your compassionate exercises from Chapter 8 to work on those issues.

From anger to assertiveness and forgiveness

We now need to think about what we can *do* when we feel angry given that, in depression, anger is often related to hurt, vulnerability or feeling blocked. What are compassionate ways to express and deal with the things that are linked to our anger? One way is to develop assertiveness.

Assertiveness

What is assertiveness?

Research has suggested that assertiveness is related to many types of behavior. Willem Arrindell and his colleagues in the Netherlands suggest there are at least four components to it:¹

- 1 **Display of negative feelings.** The ability, for example, to ask someone to change a behavior that annoys you, show your annoyance or upset, stand up for your rights, and refuse requests. This is what most people are thinking of when they talk about ‘being assertive’.
- 2 **Expressing and coping with personal limitations.** The ability to admit to not knowing or uncertainty about something rather than feeling ashamed to admit to it. Assertiveness also links to the confidence to acknowledge making mistakes, and to accept appropriate criticism. This aspect of assertiveness also covers the ability to ask others for help without seeing this as a personal weakness.
- 3 **Initiating assertiveness.** The ability to express opinions and views that may differ from those of others, and to accept a difference of opinion between oneself and others.
- 4 **Positive assertion.** The ability to recognize the talents and achievements of others and to praise them, and the ability to accept praise oneself.

Assertiveness is practising how to be open and honest as well as able to offer personal views and values and reach out to others. Assertiveness takes practice, and we can feel more confident in some situations and with some people than with others.

Non-assertive, aggressive and assertive behavior

When people have problems in acting assertively, they are either highly submissive, fearful and prone to back down when faced with conflicts, or may become overly

dominant and aggressive. Table 20.1 outlines some differences between non-assertive, aggressive and assertive forms of behavior, showing the contrasts in non-verbal behavior, feelings and thoughts.

Interestingly, non-assertive (submissive) and aggressive people can share similar beliefs. For example, both can think in terms of winners and losers. Aggressive people are determined not to lose or be placed in subordinate positions – ‘I’m not going to let them win this one’. Depressed people can feel that they have already lost and are in a subordinate position – ‘I can’t win’, or ‘I always lose’. Sometimes this seems like a replay of how they experienced their childhoods. Parents were seen as powerful and dominant and they (as children) felt small and subordinate. Depressed people can, however, be aggressive to those they see as subordinate to themselves (e.g., children). The important thing is to remind yourself that while it might have been true that, as a child, you were in the subordinate position, you don’t have to be now. You can look after yourself and treat others as your equals. You are an adult now. You might use the motto, ‘That was then. This is now’.

TABLE 20.1 NON-ASSERTIVE, AGGRESSIVE AND ASSERTIVE FORMS OF BEHAVIOR

Non-assertive	Aggressive	Assertive
Looks down or backs away	Stares and 'looks' angry, threatening	Meets eye contact but avoids 'the angry face'
Tries to signal 'no threat'	Wants to signal threat — to be obeyed	Wants to signal 'listen to my point of view'
Allows other to choose for self	Chooses for (and imposes on) self and others	Tries to reach agreement
Feelings		
Is fearful of the other	Is angry or enraged with the other	Tries to control both anger and fear
Hurt, defeated	Feels a victim and sense of injustice	Recognizes that one can't have everything one wants
Thoughts		
My view is not important	My view is the most important	All views have a right to be heard
I don't deserve to have this need, want or desire	My wants and needs are more important than other people's	Each person's needs and wants are important
I will lose	I will (or must) win	It is preferable for no one to win or lose but to work out how to give space to each person
I am inadequate or bad	I am good and in the right	Right and wrong is all-or-nothing thinking and labelling. It is preferable to work out what the issues are rather than labelling or attacking the person or oneself
Just here to please others	Others should do as I want	We should try to please each other in a mutually sharing and caring way
Self-attacking	Other-attacking	Avoids attacking

One way to feel more equal to others is to notice the 'all or nothing' of your thinking (powerful/powerless, strong/weak, winner/loser) and by considering that, 'It is not me against them. Rather, we each have our own needs and views'. To be assertive, then, is to not see things in terms of a battle, with winners and losers. This may mean that you have to be persistent but not aggressive. The angry-aggressive person wants to win by force and threat; the assertive person wants to achieve a particular end or outcome and is less interested in coercing others or frightening them into submission — and will often accept a fair compromise.

A second aspect of assertiveness is that it focuses on the issue, not the person. To use a sporting metaphor, it involves learning to 'play the ball, not the player'. In this case we speak of our wants or hurts without alarming others or employing condemning styles of thinking. For example, these are typical responses of someone who is angry and aggressive towards someone else:

- You are a stupid person (all-or-nothing thinking and labelling).
- You are always so thoughtless (overgeneralizing and discounting the positives).
- I can never trust you (all-or-nothing thinking and discounting the positives).
- You are a selfish bastard (just about all the styles!).

Of course we might all think these things, and say them too, but the point is to maintain our wish to find more compassionate ways to deal with things that upset us. Don't blame yourself, but refocus on your goal. Note that all these statements attack the other *person*, rather than addressing a specific issue or behavior. When people feel attacked, they tend to go on to the defensive. They lose interest in your point of view and are more concerned with defending themselves or counter-attacking. The assertive response focuses less on threatening or attacking the other person but more on specific issues, explaining our feelings and concerns and the quality of our relationships with others. Thus, in acting assertively we would explain in what way a particular action or attitude is hurtful. For example:

- When you 'behave' in that way, I feel hurt because I think that you don't care about me (you make clear your thoughts and concerns).
- If you 'say' things like that, I feel you are discounting my point of view.
- I feel much happier when you 'behave' like this (...) towards me.
- I accept that you feel like that, and understand why; however, my point of view is this.

Can you see the steps here?

- 1 Acknowledge your anger.
- 2 Recognize in what way you feel hurt (and, of course, try to discover if you might be exaggerating the harm or damage done).
- 3 Focus on what this hurt is about and your wish to have the other person understand your feelings and your point of view.
- 4 Don't insist that the other person absolutely must agree with you.

In assertiveness, we remain respectful of the other person. Winning, getting your own back or putting the other person down can have a negative outcome. In fact, even if you are successful (i.e. you win), the other person may just feel resentful and wait for a chance to get their own back on you! Winning can create resentful losers.

Avoiding spreading guilt

One word of warning. When you acknowledge your hurts assertively, this doesn't include making the other person feel guilty or ashamed. Sometimes people don't want to share with others what they want to change, but just want to make the others feel bad. When they discuss the things they want to change, they do it in a rather whining, 'poor me' way. Or they may say, 'It's all your fault that I'm depressed'. They may think, 'Look what they've done to me – I'll make them feel guilty for that. Then they'll be sorry.' This is understandable but not helpful. Getting your own back by trying to make people feel guilty is not being assertive. You may at times wring concessions from others, but usually people feel resentful if they have to give in because they have been made to feel guilty. I am sorry to say that some depressed

people can do that – and children of depressed parents testify to it. All we can do here is be honest and try to spot our unhelpful behavior and change it.

Sometimes we might even do things to ourselves to try to make the other person feel guilty. After an argument with her mother, Hilary went home and took an overdose. Later she was able to recognize that she had been angrily thinking, ‘She’ll be sorry when she sees what she made me do’. Nobody can *make* us do anything – short of physical coercion. It was Hilary’s anger that was the problem. Her mother had been critical of her, but at the time Hilary had not said anything, although she had felt anger seething inside her. Her overdose was a way of trying to get her own back. With some courage and effort, Hilary was able to be assertive with her mother and could say things like: ‘Look, Mother, I don’t like the way you criticize me. I think I’m doing an okay job with my children. It would help if you focused on what I do well, not on what you think I do badly.’ This took her mother aback, but after that, Hilary felt on a more equal basis with her mother.

Sometimes depression itself can be used to attack others. Hilary also came to realize that, at times, she did feel happy but refused to let others know it. She wanted to be seen as an unhappy, suffering person, and that this was other people’s fault and they should feel sorry for her and guilty. It was also an attempt to evoke sympathy from others – although it rarely worked. She had the idea that, if she showed that she was happy, she would be letting others off the hook for the hard times she had had in the past.

Sometimes there is a message in our depression. It may be to force others to look after us, or it may be to make them feel sorry for us. We find ourselves turning away from possible happiness and clinging to misery. Somehow we need someone to recognize our pain, apologize, or maybe feel sorry for us or rescue us – and we are not going to budge until someone does. It can be helpful to think carefully about how you want others to respond to your depression. It can be a hard thing to do, and you might see that sometimes we use our depression to get our own way or get out of doing things. Try not to attack yourself about this; you are far from alone in doing it. Your decision is whether to go on doing it or whether you can find other ways to make your voice heard. Using your own rational and compassionate mind can help you move forward.

Turn away from sulking

Another non-assertiveness problem is sulking, or passive aggression. In sulking, we don’t speak of our upsets but close down and give people the ‘silent treatment’. We may walk around with an angry ‘stay away from me’ posture, or act as if we are really hurt, to induce guilt. Indeed, our anger is often written all over our faces even as we deny that we feel angry. We have to work out if our sulking is a way of getting revenge on others and trying to make them feel guilty. Are we sulking in order to punish others? Always be kind to your sulking – but recognize it as a rather stuck state. Try to work out why you act that way. What stops you from being more active and assertive? What would you fear if you changed and gave up sulking?

You may feel powerless to bring about changes. This may be because you believe that direct conflict would get out of hand, or to show anger is to be unlovable, or because you think you would not win. However, sulking does have powerful effects on others. Think how you feel when someone does it to you. The problem with

sulking is that it causes a bad atmosphere and makes it difficult to sort out problems. When you sulk, you give the impression that you don't care for others. Sulking is likely to make things worse. Another problem is that sulking often leads to brooding on your anger. The more you do this, the more you will want to punish others.

You'll find that, if you can learn to be assertive and explain what it is that you are upset about, you will feel less like sulking. It might be scary, but the more assertive you are rather than sulking, the more powerful you will feel. If in a sulk, be mindful – stand back from your feelings and how your body is pushing you to act and see what happens if you view those feelings compassionately – don't fight 'the sulk' but compassionately steer your way out.

Anger at failed assertiveness

A common occurrence is that we can become angry with ourselves for not being assertive. We have probably all had the experience of getting into a conflict with someone and not saying what we wanted to say. Then later, maybe going over it in bed that night, we feel very cross for not standing up for ourselves. We feel that we have let the other person win or get away with something. Afterwards we think of all kinds of things that we could have said but didn't think of at the time. Then we start to brood on this failure to be assertive and our self-criticism can really get going.

Roger was criticized in a meeting, which he felt was mildly shaming. He actually dealt with the situation quite diplomatically but, in his view, did not defend himself against an unfair accusation. Later that night and for a number of days afterwards he brooded on his failure to say what he had really wanted to say. These were his thoughts about himself:

- There you go again – letting people walk all over you.
- You never stand up for yourself.
- You've shown once again that you're made of mush.
- You've failed again.
- You're a really weak character.

Roger had a strong ideal of himself as a 'person to be reckoned with', but of course, he rarely lived up to this. As in the case of Allen (discussed on pages 457–8), who had to take early retirement, when Roger was out of the situation he started to activate his own internal fight/flight system and brooded on what he wished he had said. At one point, he had fantasies of revenge, of physically hitting the person who had criticized him. As with Allen, Roger's thoughts led to some agitation.

The following are alternative coping thoughts that Roger could have considered:

- First be understanding and compassionate to the distress.
- That was unfair of Harry to be critical of me, and upsetting. It is very understandable for me to feel like this, as no one likes to be criticized and I've always been a bit shy.
- However, my disappointment at not saying more has turned into an unfair self-attack which is not kind or helpful to me.

You will be aware by now that the most damaging aspects of Roger's internal attack were the thoughts of having failed and labelling himself as weak. These

thoughts placed him in a highly subordinate position and were quite at odds with his ideal self (see next chapter). They activated a desire for revenge. Because of the way our brains work, it is quite easy to get into this way of thinking if we feel that someone has forced us into a subordinate position. We have to work hard to be compassionate with ourselves. Here are some alternative coping thoughts that can interrupt this more automatic subordinate thinking style:

- By globally labelling myself as weak, I feel bad. This is all-or-nothing thinking and ignores the positive aspects of my life. It makes me feel much worse. I was criticized – unfairly, in my view – but this is not the same as being ‘walked all over’.
- It may be true that I need to learn how to be more assertive, but this is going to be hard to do if I take each failure to assert myself as evidence of weakness. There are many areas of my life where I have shown some courage, but in any case, conflicts are often complex and cannot be reduced to simple ideas of weak/strong. Other people later agreed that the criticism was unfair, so they don’t see me as weak.
- If a friend had been in a similar situation, I would not have attacked him or her in the same way that I attack myself – for I know that this would have made him or her feel much worse.

Read these through again but this time with as much warmth and understanding as you can muster. Do you notice how it feels when you put warmth into it? If we approach the problem compassionately and think about what would be helpful, we might identify a need to use assertiveness. We could then plan what we wanted to say (but didn’t) and calmly try it out. The problem for Roger was that he never tried assertiveness but only felt disappointed with himself and then became angry. He never gave himself the chance to improve his assertiveness.

You can use these basic ideas in all kinds of relationships, including of course close ones.

Forgiveness

There is much research showing that learning forgiveness, and working through the difficulties of forgiving, helps our mental health.² If we carry a lot of anger for people we feel have hurt us in the past then this anger can sit in our minds and we often return to it – constantly stimulating our threat system. Deciding to walk the path to forgiveness can be a major way of moving forward. There are many aspects to forgiveness that we need to clarify. One cannot ‘make’ oneself forgive and sometimes we need time to heal – so no ‘I should’ or ‘I ought’ here. Forgiveness is about taking the steam out of one’s anger to others and in so doing no longer filling one’s mind with angry, vengeful or victim thoughts. It is *not* about liking, wanting to, or feeling one should want to see or relate to the person you forgive. It is not about accepting that their behavior was okay when it was not. Forgiveness does not mean that what happened in the past does not matter, or forgetting. Rather, it is the effort made to give up the desire for revenge or punishment. In brief, these stages are:

- An **acknowledgement and uncovering phase** of harm done – this means facing one’s hurt.
- A **recognition** of how ‘holding on to one’s anger and hurt’ is damaging to oneself.
- A **recognition phase** of the personal benefits of forgiving. Spend time imagining what

you would feel like if you let go – really see yourself in the future free from what you find hard to forgive.

- A **decision phase** to move and work towards forgiveness involving commitment to forgive.
- A **working through phase** involving the acceptance of others as fallible and flawed, that disappointment is inevitable
- An **outcome phase** acknowledging the benefits of forgiveness.

If forgiveness is an issue for you, it may be helpful to put time aside where you will not be disturbed, engage in your soothing breathing rhythm and then bring to mind your compassionate self or compassionate image(s) (see Chapter 8). Then gently work through each of the above phases. Make notes to yourself about your thoughts and feelings. You might like to write a compassionate letter to yourself on the benefits of forgiving and fears and blocks of forgiving.

Resentment and revenge

Forgiveness can be a lengthy process requiring the acknowledgement of much hurt. Some people may try to forgive without acknowledging their own pain and anger, but when they do this, resentment usually remains. Forgiveness can be a painful process. Learning how to forgive is about learning how to let go of anger. A need for revenge can be damaging to ourselves and our relationships. We may tell ourselves how justified we are to be angry *regardless of how useful this is*.

Judy felt much anger against her parents for their rather cold attitude, and blamed them for her unhappy life. In doing this, she was in effect saying to herself, 'I cannot be better than I am because my parents have made me what I am. Therefore, I am forever subordinate to them – for they held the power to make me happy. Therefore, I can't exert any power over my own happiness.'

Gradually Judy came to see that it was her anger (and desire for revenge) which locked her into a bad relationship with her parents. Forgiveness required a number of changes. First, she needed to recognize the hurt she felt, which to a degree was blocked by her anger. Second, she needed to see that she was telling herself that, because her parents were cold towards her, she was 'damaged' and destined to be unhappy – that is, she was giving up her own power to change. She realized that she felt a 'victim' to her childhood. Rather than coming to terms with this, she felt subordinated and controlled by it. While it is obviously always preferable to have had early loving relationships, it is still possible to move forward and create the kind of life one wants. As Judy came to forgive her parents (but not condone them), she let go of her anger and felt released from the cage in which she had felt trapped.

When we forgive, we are saying, 'I let the past go and am no longer its victim'. One patient said that, by giving himself the power to forgive, he was giving himself the power to live. Forgiveness is not a position of weakness. Some people find that 'letting go' feels like a great release. Remember you may never like or want a relationship with the person you forgive – rather, you let go of your anger.

Self-forgiveness again

We looked at self-forgiveness in the last chapter but because it is so important for us let us look at this once again. Self-forgiveness can go through the same phases as forgiving others:

- An **acknowledgement and uncovering phase** of how you might be self-critical and self-shaming. This means being fully open and honest with yourself and really attending to how you think and treat yourself unkindly.
- A **recognition** of how holding on to one's self criticalness and anger or disappointment with oneself is damaging to oneself? It is not stimulating those feeling systems that are conducive to well-being.
- A **recognition phase** of the personal benefits of recognizing oneself as a fallible human being and that learning to be more gentle, kind and forgiving is beneficial to one's moods and well-being (see also page 299 on the difference between compassionate self-improvement and shame-based self-attacking).
- A **decision phase** to move and work towards self-forgiveness, involving commitment to forgive. Make a decision that you are going to be a forgiving self-improver rather than a condemner (see Chapter 13).
- A **working through phase** involving the acceptance of yourself as a fallible human being who just 'found themselves here' trying to do the best you can.
- An **outcome phase** acknowledging the benefits of self-forgiveness.

Forgiving ourselves means that we treat ourselves with compassion. We do not demand that we are perfect or don't make big mistakes from time to time. There are many spiritual traditions that recognize the great importance of forgiveness.

Reconciliation

Some depressed people also have difficulty in reconciling and making up after conflicts have taken place. Couples and families with high levels of conflict but with good reconciling behaviors, and who value each other, tend to suffer less depression. When we reconcile and make peace, our anger and arousal subsides. Chimpanzees, our nearest primate relatives, actually seem better at reconciling their differences than some humans. Research shows that, after a conflict, they will often come together for a hug and embrace and they rarely stay distant for long.

So why is it difficult for some people to reconcile and make up? Some typical unhelpful thoughts that can make reconciliation difficult include:

- I must make them pay (feel guilty) for upsetting me.
- If I forgive them (or me) I am letting them (or me) off the hook.
- If I forgive them then I can't express my dissatisfactions.
- I'll have to be nice.
- Forgiveness is a position of weakness.
- It has more benefits for them than me.

If I apologize and want to reconcile, it means:

- I'm admitting I was in the wrong.
- I am giving in.
- I have lost.
- I am weak. Strong people do not apologize.
- Others will think I have taken full responsibility for the conflict.
- I am in a subordinate position.

In some cases, it is because as children we were never taught how to do it, and now as adults, we feel awkward about it. Perhaps neither they nor their partners know how to make the first move to make peace. Another reason is that one or both parties in the conflict will not reconcile until they are given the dominant position: they must win, get their own way and assert their authority. The one who reaches out to make peace is perceived as the one who has submitted.

For example, Angela said that, when she was a child, it was always her and not her mother who had to say she was sorry. If she didn't, there would be a very bad atmosphere between her and her mother, which she found intolerable. Her mother would sulk, sometimes refusing to speak to Angela until she had apologized. When she did, her mother would remind her of the conflict and how naughty Angela had been. At a time when Angela was reaching out for acceptance, her mother would make her feel bad, ashamed and guilty again. Angela developed an expectation that, if she apologized, the other person would use this to make her feel bad about herself and would not accept her peace-making efforts without 'rubbing her nose in it'. She was therefore very frightened of conflicts because there was no way she could reconcile afterwards without always feeling in the wrong.

There are various alternatives to the above unhelpful thoughts and ideas. For example:

- I can apologize for my actions if I think I have hurt someone, but this does not mean that the conflict itself was all my fault. Indeed, it is preferable to think in terms of differences of opinions or desires rather than in terms of blame (see the responsibility circle in pages 283–6).
- Assertiveness is not about winners and losers but about being clear about the reason(s) for a conflict and attempting to resolve it.
- The ability to apologize and repair a relationship is a compassionate positive on my part, not a weakness.
- I don't have to grovel when I apologize, but rather to get together with the other person again because I care about the relationship.
- I can focus on the issue of coming together rather than on just relieving myself of guilt.

Reconciliation, like much else in assertiveness, is a skill that can be learned. It may be difficult at first, but if you set your mind to it, you will improve. Learning how to make up after conflicts makes them less frightening. It helps us stop ruminating on the anger and conflict and building up the other person into a real ogre! You learn that you can survive conflicts, they are a normal part of life and we may actually benefit from them. Making up is only a submissive position if you tell yourself it is.

Reconciliation in intimate relationships may involve hugs and other physical contact, but of course, you can't force this on others. If others are not ready to reconcile, all you can do is to state your position – that you'd like to make up. Be honest and offer an apology if you need to, and wait for the other person to come round in their own time. If they don't, avoid getting angry with them because they don't wish to go at the same pace as you.

One other thing that men especially need to be cautious of is encouraging their partners to prove that they are now reconciled with them by agreeing to have sex. If you do this, it is possible that your efforts at reconciliation will not be seen as

genuine, but only as a tactic to get your own way. If your partner does not want to have sex, you may read this as ‘Well, she does not really care for me, otherwise she would’. This can lead to anger and resentment again. If you feel that there is not enough sex in your relationship, this is best sorted out at some other time, calmly, and with no threat of ‘If you loved me, you would’.

Overview

Feelings of anger and powerlessness can haunt you in depression because they stimulate the threat system. When that happens, the levels of stress hormones in our bodies increase. Healing then is about learning how to work with the feelings of anger and powerlessness, by being honest, learning assertiveness if we need to (and this may take some practice) and learning forgiveness. These are not easy steps, and in many spiritual traditions they can be seen as lifetime guides. If you practise developing your compassionate self, and really orientate towards developing that within you, this may help you in these tasks.

KEY POINTS

- It is the message or meanings in anger that need to be considered rather than the anger itself.
- In learning how to be assertive, we focus on the hurt and the issue(s) behind a conflict rather than attacking either ourselves or the other person.
- Non-assertive behaviors include aggression, inducing guilt, sulking and backing down fearfully.
- Anger at our own lack of assertiveness is a common experience. This self-directed anger can be more damaging to us than the lack of assertiveness itself.
- Because anger and assertiveness nearly always arise in situations of conflict, it is important that, after the conflict has passed, there is reconciliation and forgiveness. These may not take place if there are specific beliefs that stop them – for example, ‘To apologize is to admit I was in the wrong, or that I am letting people off the hook’.
- Forgiveness is actually an assertive action because we give ourselves the power to forgive and thus release ourselves from feelings of having been a victim for which we must seek revenge.

EXERCISES

Exercise 1

Think of an area where you would like to be more assertive – maybe something small to begin with. For example, suppose you need a new pair of shoes. Go into the shop and spend time trying on several different pairs – then thank the assistant and walk out, without buying anything. Or think about something you might really like to do with a friend or partner and ask them. If they turn you down, then smile and be pleased you had a go. Notice, be mindful and compassionately smile at any tendencies to become critical and ruminating. Try something each day or as often as you can – practise, practise.

If the issue is becoming more assertive in conflicts then:

- Avoid attacking the other person: that will put them on the defensive.
- Work out what you want to say, focusing on a specific issue.
- Be brief and clear.
- Be prepared to ‘trade’ and compromise.
- Avoid seeing either as signs of weakness.

Here’s an example involving Emma and Chris, whom we met earlier (see pages 448–9). Emma was angry about Chris’s lack of helping around the house. However, she waited until they were relaxed together and then said:

‘You know, Chris, I wish we could spend more time together. However, I’m so busy with the house and it would be really helpful if you could lend a hand. I feel really left out when you go off to see your friends and I’m stuck here doing the ironing. It’s not that I want to stop you going out but that I want to have more time, too. Look, I’ve worked out that, if you do more of the shopping and vacuuming I would have more time for myself. I’d really feel a lot better and not feel so taken for granted.’

Of course, this may not do the trick straight away, but it's a start. Sometimes it helps to rehearse what you want to say – that is, rehearse your assertiveness skills. Remember, it is a step-by-step process and does not have to go perfectly first time. By preparing what you want to say, rather than waiting until you get angry and rushing in with attacks, you are more in control and will often achieve more.

If you are prone to getting angry with yourself for not being as assertive as you would like to be, review the example of Roger on pages 479–81. Work out if you are attacking yourself. Then rehearse the types of assertive things you would like to say. Say them out loud. Get used to speaking them and hearing yourself say them. Avoid brooding on your anger and on all the really nasty things you could say. You know that you probably won't say them so there is no point in rehearsing them. Try out only those things that you think you should say.

An important aspect of acting assertively is 'slowing your thoughts down' to give you space to think. If you get into a conflict situation, don't feel that you have to respond immediately. One way to do this is to ask the other person to tell you more about what concerns him or her, rather than trying to defend yourself immediately.

You then might say to the other person, 'I can see how you could think of it that way, but this is how I see it'. Be factual rather than accusing. Stick to the issue at hand rather than trade personal attacks.

Spend time thinking about forgiving others and letting go of the past. Write down the advantages and disadvantages of doing this. If you could let go of the past (and any desire for revenge you might feel), how would this help you? What stops you? What are your thoughts here? Use your rational/compassionate mind to help you.

If you feel that some of the hurts from the past are very serious, and it is impossible for you to embark on this journey alone, think about seeking help. The moment you say, 'I no longer want to remain a victim of my past' you are taking the first step up and out.

Exercise 2

Try your compassion practice. First, sit or lie down somewhere comfortable. Go through a relaxation exercise of the type described on pages 130–3. Enter into your compassionate self mode and feel yourself expanding; focus on your kind and gentle facial expression. Sense how you think about things and the tone of your voice. Now imagine a person whom you want to forgive standing in front of you. See their facial expression and feel compassion for them. Remember that they just 'found themselves' here. If you find yourself being pulled back into your anger, break contact with the image, refocus on the compassionate self and begin again. As you feel compassion, notice what happens to the image that is the focus of your forgiveness. It might shrink or move away from you. Remember, you are healing yourself here because it's your holding on to your anger that's causing you pain. As your image recedes it is grateful for your letting go.

Remember that forgiveness doesn't mean that you like the person you have forgiven. You may never want to see them again. It's all about changing your emotional orientation.

Exercise 3

This time the focus is on a part of yourself you want to forgive. You can go through exactly the same procedure as in the previous exercise. When in compassionate self mode, imagine that part just in front of you. Then imagine forgiving that part of you with a compassionate heart. If you get pulled into angry critical mode, pull back into the compassionate self and focus on your breathing and sense of warmth.

Whatever works for you, use it. The idea is to develop the inner art of forgiveness. Forgiving yourself does not mean an end to trying to improve. It just means that improving and changing will be easier for you if you don't hang on to things from the past that cannot be changed.

Dealing with frustrations, disappointments and lost ideals

Many therapies focus on the importance of learning to cope with disappointments, setbacks and tragedies with forms of acceptance, coming to terms, not self-attacking and or not insisting on ‘it must’ or ‘must not’ – these are also old wisdoms.¹

Our emotional reactions to frustration and disappointment depend on the importance we place on things. The most common are:

- When things don’t work right or as we think they should.
- When we make (what we think are) avoidable mistakes. (I can get quite frustrated with myself if I bowl badly at cricket or drop that catch!)
- When others do not behave, or feel about us, as we want them to – e.g., don’t show us enough respect, affection or break promises.
- When we ourselves lack an ability to do or achieve something we want.
- When we feel certain things – for example we feel depressed and lose energy, don’t feel as positively about someone as we would wish, feel disappointed in ourselves because we lose the ability to feel affection or lose sexual feelings.

Shoulds and oughts

Disappointment is a major area where our shoulds and oughts (see page 454) come to the fore (as do our ‘musts’, see page 215). We can believe that things, ourselves or other people ‘should be like this’ and ‘should not be like that’. The problem here is that, life being what it is, it does not respect our shoulds and oughts. Some of us feel that we should not have to die, and instead of coming to terms with it, rage about the fact that life ‘shouldn’t be like this’. Sometimes our shoulds stop us from doing the emotional work we need to do, to come to terms with things *as they are* and work out helpful solutions for dealing with them.

We can develop a strong sense of ‘should’ when it comes to our own attitudes – about ourselves, e.g., ‘I *should* work harder’, ‘I *should not* make these kinds of mistakes’, ‘I *should not* be angry’, ‘I *should* love my parents and be more caring to them’ and feeling very disappointed when things don’t turn out as our ‘should’ says. Shoulds often involve anger and attempts to force ourselves to be different. When we rigidly apply the shoulds to ourselves, we inevitably end up bullying and attacking ourselves. It is as though we struggle to avoid accepting our limitations, setbacks or true feelings. In the 1940s the American psychotherapist Karen Horney called ‘the shoulds’ ‘a tyranny’.

When we apply shoulds to other people, we often feel angry with them when they disappoint us. Instead of seeing them as they really are, we simply say ‘they *should* be like this’ or ‘they *shouldn’t* be like that’ (see page 454). Strong shoulds often reduce our tolerance for frustration, and as we shall see shortly, shoulds and oughts can lead to serious problems with disappointment.

When you’re working compassionately it’s always worth asking yourself, ‘What’s the fear, what’s the threat behind my should, my ought or my must?’ There are not that many: they boil down to the fear of rejection or being marginalized, being shamed, being hurt or criticized, or a loss of control. It is because the threat system is involved that we often have problems with frustration.

The problems of perfectionism

Depressed people are often surprised when I suggest that ‘*the secret of success is the ability to fail*’. So much in our society concentrates on succeeding and achieving things that we can become fearful of, or even *incompetent* at failing. Yet, if you think about it, success, like love, looks after itself. Most of our problems don’t come from succeeding or doing well but from failing and not doing well. The way we cope with disappointment and setbacks can do much to throw us into depression, especially if we spiral into self-attacking and self-dislike. Learning how to fail without self-attacking can be a useful means of exerting more control over our moods. One reason why failure becomes a serious problem is because, perhaps without realizing it, we have become overly *perfectionist* and *competitive* people to whom the idea of failure is a terror.

Perfectionism relates to having high ideals and believing that we must reach them or else we are worthless and bad in some way. Research by the Canadian psychologists Paul Hewitt, Gordon Flett and their colleagues suggests that there are three forms of perfectionism:

- Self-orientated perfectionism: Here the focus is on high standards and the need to be perfect. When people fall short of these standards, they can become self-critical and experience a lot of frustrative anger.
- Other-orientated perfectionism: Here people demand high standards of others. They can become angry with others if others are not up to the mark. The other-orientated perfectionist may look for how far people fall short of a standard rather than how good they are.
- Socially prescribed perfectionism: Here people believe that it is others who expect high standards of them and that they will be rejected or shamed if they don’t come up to those expected standards. This form of perfectionism is the most strongly linked to depression.

Doing your best

Some forms of perfectionism are very helpful. You would like your brain surgeon to be a bit perfectionistic! Most of us accept that trying to do our best is a good idea. If something is worth doing, it’s worth putting some effort into it. The problem is: how much effort? Even if you work 20 hours a day, you might, in principle, say that you could have worked 21 hours a day. When we are in perfectionist mode, if we fail, we

inevitably say we could have done more. The problem is clear – the goalposts keep moving.

It's similar for 'other-orientated' perfectionists. Even if you put a lot of effort into something, if it is not exactly what they wanted, they will say that 'you could have done more'. They can be very undermining – so watch out for them – they are often demanding and not always supportive or able to appreciate one's efforts. Children, for example, will have problems in judging what is reasonable effort and what is not.

Regarding our own judgements about ourselves, it's not so much our desire for high standards – which can be driven by a passion to do well that causes trouble (see page 299) – it is when our perfectionism is driven more by fear of failure and fear of being criticized by other people and our self-criticism. Seeking high standards is important but once again it's what drives this and what happens in us if we don't quite make it; can we be self-accepting, kind, understanding and encouraging to ourselves in contrast to being very angry, self-critical and/or frightened of what other people think and will do? What is the true motivation for our drive to be perfect? If in our hearts we know that actually we drive ourselves because we are frightened, then we need to look at this – work on the fear. Research has shown that perfectionism is associated with a range of mental health problems, especially those linked with depression.

If you think you are a perfectionist then:

- Spend some time exploring in what ways perfectionism works for you. Do you put yourself up on the high wire trying to achieve too much?
- What are the advantages and disadvantages of your perfectionism style? Spend time on this really reflecting on these themes so that you can 'feel' how they are working in you.
- If you are not able to reach your standards, what are your greatest fears? Spend some time to note them – bring them to light.
- What feelings and thoughts do you have about yourself and how do you treat yourself? Can you distinguish being upset with an outcome and becoming self-critical in unhelpful ways?
- Is this linked to childhood?
- With kindness and openness, decide if this is helpful and, if not, how you might like to change things – to focus on your efforts and learn to value those – not just results.
- What would be compassionate attention, compassionate thinking, compassionate actions and behavior, and compassionate feelings in such situations?

Frank, an artist, told me how he would fly into rages and rip up his work if he could not make the image that he had in his mind appear on the canvas. This is an example of perfectionism driving us into low frustration tolerance. Even in sex, perfectionists may be more focused on how they perform than on getting lost in the pleasure of it. They have to 'do it right'. A patient of mine who used to go hiking, noted that he could have been walking anywhere; what seemed to matter more was how many miles he covered. He would set himself tests – 'Can I walk 20 miles today?' Even if it had been a bright and beautiful day and the countryside had been in full bloom, he would hardly notice this, because he was so intent in doing his set number of miles often as quickly as possible. Not very mindful!

At one level, we may see this as 'gaining pleasure from achievement'. Such pleasures are short lived, do not stimulate the contentment/soothing system, and because the next 'need to achievement' pops up quickly we lose the ability to take

pleasure for each moment – to be fully present (see Chapter 7). Of course, in depression, there is often a sense of not achieving enough and certainly a loss in the ability to enjoy the simple pleasures of life.

The disappointment and dissatisfaction with performances that perfectionists feel can result in a number of difficult emotions: guilt, anger, frustration, shame, envy and anxiety. These negative emotions can make life a misery. Even if successful, we know this may not be enough because we might think that people are only interested in us because of our success and not because they really care. Various famous people can get depressed with problems like this – success does not really give that sense of connection and belonging that they were looking for. To get those feelings we have to retrain our brains and reach out to others.

Ask yourself: Why do I want to reach the standards that I've set myself? You have to be really honest in your answers. Here are some that others have given:

- *I want to impress others.*
- *I want to be a somebody rather than a nobody.*
- *I want to be loved and wanted.*
- *I don't want others to see the bad side of me or my flaws.*
- *I want to avoid being criticized and thought of as worthless.*
- *Life is pointless if you don't succeed.*
- *I must not let others down.*
- *There has to be something I am good at.*

It does not matter too much what your wants, wishes and hopes are, provided that you can cope with them not coming to fruition. If you say, 'I'd like to impress others,' that may be fine. But if you say, 'I must impress others, otherwise they will see me as inadequate and I will feel useless and rejectable,' you have a problem. And the reason why is that failure and setbacks will generate such anger with yourself and others that this can drive you into depression.

Here are some useful ways to cope with these difficulties. Keep in mind that some of your perfectionistic difficulties are fear-linked or simply bad habits. Make a decision to compassionately refocus your attention and practise the following:

- When engaged in activities such as walking, or cooking or sexual behavior become mindful (see Chapter 7).
- Take some soothing rhythm breaths and pay attention to the present moment. If out walking look at the sky, the trees and grasses – really attend to them; smell the air, playfully notice each step.
- If other thoughts drift into your mind that are not exactly about this moment (and they will) notice them kindly and bring your attention back to the sky, trees, grass etc.
- Remember to use your compassionate facial expression.

Personal pride and perfectionism

Some people with eating disorders, who become very thin, are often highly perfectionist and competitive. They have a pride in themselves because they exert control over their eating and weight. Often the problem starts when they get on the scales, see that they have lost weight and feel a thrill or buzz of pride from the achievement. To put on weight produces a feeling of deflation and shame. They can become obsessed with every calorie and type of food they eat. This is an example of

shame-driven pride. They may feel ashamed of their bodies or believe that there is not much about them to be proud of but then they hit on the idea of weight loss, and the pride of losing weight drives them on.

When shame turns into pride, it takes a real struggle to change this. Helping these people to put on weight may be seen as taking away the only thing (losing weight) they feel good at. This kind of problem is a very different one from, say, panic attacks. Nobody wants panic attacks, so therapist and patient can line up together against the common problem. Anorexic people want to be thin; they want to maintain their perfectionist standards of not eating much.

It is the same with all forms of perfectionism and competitiveness, be it cleaning the house, playing a sport well, working long hours and so on. *The person does not want to give up these things.* However, it is the reactions to failure and setbacks that have to be changed. If the sports person becomes depressed because he or she is not playing well and loses confidence in him/herself, that is hardly helpful. Many talented sportspeople do not make it because of how they react to things not going well – they can't ride the ups and downs easily because anger and frustration disrupts their performance. They cannot refocus on the last.

'What the Hell' factor

There is an important motto for when we slip into perfectionism and overstriving – which is 'what the Hell'. The fact of the matter is that once you have tried your best – if it's not working – then 'what the hell' – you are not going to be taken out and shot by the Gestapo. It is finding that point inside you that lets you 'relax, ease back and let things be'. Obviously I am applying this to perfectionism when we overly strive and get into states of panic, fear and depression. People who are lazy may need much less of 'what the hell factor' – so it's always a matter of balance. But I and my own family have found that, at times, when things seem to be getting too intense, the ability to back off and think, 'Okay, I've tried my best so what will be will be' – 'what the hell' – is helpful. Technically this is called 'de-catastrophizing and keeping things in perspective' – but 'what the hell' – it works for me so I share it with you.

Frustration tolerance

It would be great if we never felt frustrated, but while we might be able to lower our frustration threshold, the key is our ability to tolerate and work with it. That requires us to become more observant of how and when it arises in us. Our ability to tolerate frustration can change, for many reasons. You have probably noticed that, some days, you can cope with minor problems without too much effort, but on other days almost anything that blocks you can really irritate you. This is what we mean when we say, 'He (or she) got out of bed on the wrong side today'. If we are driving somewhere in a hurry, we might see others on the road as 'getting in our way' and become angry. As our feelings and attitudes become more urgent, we start to demand that things 'should be' different from the way they are. Fatigue, tiredness and being under pressure are also typical everyday things that reduce our frustration tolerance. *And depression itself can lower our frustration tolerance.*

The degree of frustration that a person feels can relate to a fear of shame. For

example, Gerry lost his car keys on the day he had an important meeting. He became angry with himself and his family because the keys could not be found. In the back of his mind, he was thinking, 'If I don't get to the meeting on time, I'll walk in late. Everybody will think I'm a person who can't keep to time and they will think I'm unreliable or careless.' At times, we may blame ourselves with thoughts like 'If only I were more careful, I wouldn't lose things'. Probably everyone could tell stories of how, when things are lost (e.g., the string or scissors are not in the drawer as expected), they became angry and irritated: 'Why are things never where they should be?' When we get depressed our frustration tolerance goes down and coping with that can be difficult. Again keep in mind that this is not your fault, it is the depression – but it is helpful to work out how to cope:

- Recognize that feeling 'on a short fuse' can be part of depression, and be prepared. Use your soothing breathing and monitor your thoughts mindfully – preparing to cope with your irritable mood today with efforts not to act it out.
- Try not to self-blame, as this will send you down in spirals – you may become frustrated with being easily frustrated.
- Advise others of this and assure them you will do what you can not to act it out.
- Take pride in the ability to feel without acting, to smile even though you are irritated inside. You're learning that you can have a choice about how you act.
- If you feel your frustration is a bit too hot to handle, take yourself out of the situation.
- Sometimes physical activity such as running or quick walking can be helpful.

Dashed ideals and fantasies

One of the most important qualities of us humans is that we *fantasize*. This means that we are constantly making plans and developing fantasies of how we want things to be. The problem with fantasy is that we often live in excess. We imagine we can do more than we can. Often I have fantasized and imagined I could complete a piece of work in a certain time only to discover I couldn't. Painters get frustrated when they cannot make the picture they are painting look like the one they have in their head. We often fantasize we are going to feel better than we do. For example, we might fantasize having a great fun holiday but it turns out to be just okay. Sometimes we fantasize about other people having fun lives and it is only us who are not. Fantasies can make us unreal-istic in many areas of our lives. The way we create our fantasies, ideals, wishes, anticipations and expectations in our heads can be absolutely crucial to our abilities to cope with the ups and downs of real life, life that rarely matches our fantasies.

Petro was a very bright student and throughout his life his single parent (and school) had admired his ability and praised him. But gradually Petro developed an idea that he needed to do very well, make his mother proud of him, be successful (not like his father) and one day rescue her from their poverty. This became linked to his self-identity. He fantasized about his career and going to the top universities. His school rather fuelled these fantasies. The problem was as his examinations approached and he had one or two lower grades he started to panic – seeing all collapse around him. He slipped into depression and could hardly work at all, seeing himself as a failure – yet he was a very bright lad! However, he was grossly over-extended and up on the high wire of life. Oliver James discusses these issues in detail

in his book *Britain on the Couch* – of how too many of our children are being set up with too high expectations and who either give up, or crash when they fall short.

We can be set up for disappointment because our ideals, hopes and expectations are unrealistic. Modern Western societies are very unhelpful here because they imply you can be anything you like if you work hard enough. *This is simply untrue*. Genes, opportunity and luck as well as effort have a big effect on how our lives turn out. Often we have to learn to play the hand we are dealt – and sometimes that is a difficult one. Learning to do that with compassion can help enormously. A serious thwarting of our life goals and ideals can trigger depression, especially if we see this as having a lot of social implications (e.g., loss of status, loss of a loving relationship) as well as implications for how our lives will be in the future. Thinking about depression often means that we have to ask ourselves several questions:

- What are our ideals?
- In what way do we feel thwarted in reaching them?
- How can we deal with the frustration and anger that comes when they are not met?
- What conclusions are we drawing about ourselves, others and the future?
- Are we caught up in a strong sense of ‘should’?
- How might we ease down and become more balanced in our expectations and aspirations?

The disappointment gap


Spend a few moments thinking about your ideals. You’ll explore this more clearly by writing down the ideal and the actual in two columns (see table 21.1). You can then think about what I call the *disappointment gap*. The disappointment gap leads to four possible outcomes:

- Attack and blame yourself.
- Attack and blame others.
- Give up.
- Accept reality without seriously attacking either yourself or others.

Because attacking is a common response to frustration, we can see that we have found a root source of our self-criticism – which is none other than our frustration. The more frustrated we are with ourselves, the more we may tend to bully and criticize ourselves. Keep in mind, as I indicated with the example above of Gerry (page 502) who lost his keys, that behind frustration can be feelings of threat, fear and anxiety – so always consider that as a possibility. Let’s work through some examples and see how this works.

Brian had set his sights on an important promotion. For over a year, he had worked hard to put himself in a good position, and his bosses had indicated that the promotion was within his grasp. He began to anticipate and plan how the new position would make his work easier and more interesting and how the extra money would allow him to move house. Unfortunately, two months before the promotion was due, Brian’s company was taken over and all promotions were put on hold. To make matters worse, the new company brought in some of their own personnel, and

Brian found that the position he was going for had been filled by a younger man. He became angry and then depressed. All the plans, hopes and goals associated with the promotion seemed thwarted. He told himself that things never worked out for him and there was no point in trying to improve himself. He ruminated on the injustice of what had happened but had little power to change the situation – in effect, in his mind he kept fighting an unwinnable battle and thus saw himself as constantly frustrated and defeated. His *ideal* in contrast to his *actual* self looked like Table 21.1.

TABLE 21.1 BRIAN'S IDEAL–ACTUAL RELATIONSHIP		
Ideal		Actual
Get promotion		Didn't get promotion
Advance in career		Stuck in career
Move house		Stuck in same house
<ul style="list-style-type: none">• Attack self. I should have seen this coming. I should feel confident enough to try to get another job, but I'm not. If I were more assertive, I'd make them give me my promotion. I'm weak for not coping with this.• Attack others. They're just using me. They're unfair, and they should be fair and realize that this promotion was promised to me by the old company. They have snatched an opportunity away at the last moment.• Give up. I can't get out of this. Nothing will change. My future is ruined.		

Of course it's understandable why Brian felt bad about this lost promotion, but ruminating on his anger and self/other attacking made a bad situation worse. For him to come to terms with what happened – the fourth possible outcome – it helped for him to recognize his sadness about it (rather than block it out with anger) and the depth of his shoulds, and stop attacking himself. He soon realized that he could not have seen it coming and that it was not a matter of him not having been assertive enough. He gradually began to work out ways that he could get around this setback, waited a while and sought employment elsewhere. Coming to accept the situation and then working out how he could deal with it were important steps in his recovery. The more understanding, compassion and kindness one can bring to this situation the better – life can be very tough.

‘It’s all been spoiled’

Depressed people often have the feeling that things have been spoiled. Susanne had planned her wedding carefully, but her dress did not turn out right and it rained all day. This was disappointing, but her mood continued to be low on her honeymoon. She had thoughts like, ‘It didn’t go right. It was all spoiled by the weather and my dress. Nothing ever works out right for me. Why couldn’t I have had one day in my life when things go right?’ She was so disappointed and angry about the weather and her dress that she was unable to consider all the good things of the day, and how to put her disappointment behind her and get on and enjoy the honeymoon. She dwelt on how things had been spoiled for her, rather than living mindfully in each new moment of her unfolding life (see Chapter 7). Later, when she considered possible positives in her life, she was able to soften her all-or-nothing thinking and to

recognize that she was seeing the weather and the dress as almost personal attacks. She realized how her anger was interfering with her pleasure. She also acknowledged that many kinds of frustrations and disappointments in her life are often activated by thoughts of 'everything has been spoiled'. She had to work hard to come to terms with her wedding 'as it was', but doing this helped to lift her mood.

The key process in these kinds of situations is:

- First, recognize the upset and disappointment.
- Then make a conscious decision that you really want to learn to calm down as soon as possible – that this is a life skill you would like to acquire and will train for.
- Then engage your soothing rhythm breathing – really focus on that.
- Then focus on being mindful and observing your thoughts and feelings – if you can, be curious: 'Oh, that's interesting, I'm thinking like that.'
- If you get 'pulled into your upset' then refocus on you breathing and either:
 - bring to mind your sense of being the self you would like to be (e.g., calm and compassionate – don't forget the gentle facial expression) and/or
 - bring your compassionate image to mind and imagine it with you, understanding the distress of your upset but there to help you.
- When you feel ready and able, think about how you might re-examine your thoughts and feelings and see them in a different way – what would a compassionate way of seeing them or thinking about them be? What might compassionate behavior be for you now? (See Chapters 8 and 9.)
- Keep in mind you are trying to turn on and stimulate your soothing system to help you in this situation (see Chapter 2).

The sense of things having been damaged and spoiled can be associated with the idea that things are irreparable and cannot be put right. In these situations, it is useful to work out how best to improve things rather than dwell on a sense of them being *completely* spoiled (which is linked to our anger). Of course, we might need time to grieve and come to terms with disappointments. One can't rationalize disappointments away. The feelings can be very strong indeed.

Sometimes we can feel we are spoiling things for others because (say) of our depression or mistakes etc. That takes us back into the realms of shame and guilt (see Chapters 18 and 19).

Loss of a positive relationship

When we fantasize about our ideal partners, we usually see them as beautiful or handsome, kind and always understanding. When it comes to sex, we may think that they (and perhaps ourselves too) should be like an ever-ready battery that never goes flat. When we think about our ideal lover, we don't think about their problems with indigestion, the times when they will be irritable and stressed or take us for granted, or that they could fancy other people.

As an adolescent, Hannah had various fantasies about what a loving relationship would be like. It would, she thought, involve closeness, almost telepathic communication between her and her lover and few, if any, conflicts. She believed that 'love would conquer all'. This type of idealizing is not that uncommon, but when Hannah's relationship started to run into problems, she was not equipped to cope with them because her ideals were so easily frustrated.

The early courting months with Warren seemed fine and they got on well and

Hannah was sure that theirs was going to be a good marriage. However, after six months of marriage, they had a major setback. The negotiations for a house they wanted to buy fell through. Then, while they were trying to find another, the housing market took off and they found that they had to pay a lot more for one of similar size. Warren felt cheated by life, his mood changed and he became withdrawn and probably mildly depressed. Hannah, who was also upset about the house problems, was more concerned about the change in her relationship with Warren. The gap between her ideal and the actual relationship started to widen. This discrepancy in her ideal-actual relationship looked like Table 21.2.

Gradually Hannah began to recognize that their problems were not about love but the hard realities of living. There was nothing wrong with her as a person or the relationship if Warren felt down. They had to learn to deal with their problems in a different way by encouraging each other to talk about their feelings. Hannah had often avoided this for fear that Warren would blame her or say that she was, in some way, part of the reason why he was feeling down. She also had to give up attacking him when he did not give her the attention that she wanted.

TABLE 21.2 HANNAH'S IDEAL-ACTUAL RELATIONSHIP	
Ideal	Actual
Have fun together	Can't go out, short of money
Have few conflicts	Increasing conflicts
Always feel understood	Don't feel understood
Feel close to each other	Feel increasing distance
<div>DISAPPOINTMENT GAP</div> <div><ul style="list-style-type: none">• Attack self. Maybe I'm doing something wrong. If Warren cared for me, he would talk to me more. Maybe he doesn't love me any more. I get irritated with him so maybe it's my fault. He's lost interest in sex, therefore I am not sexually exciting any more. I should be able to cope better. Maybe I made the wrong choice of partner.• Attack other. This is a different side to him. He should cope better and recognize my needs. He's being selfish and moody.• Give up. There's no point in talking about what's wrong. We can't change the housing market. I'm stuck.</div>	

She slowly moved away from thinking that all problems in their relationship were to do with a lack of love. Warren had to acknowledge the effect his moods were having on Hannah and that he needed to work through his sense of injustice and belief that this was unfair and it shouldn't have happened. They eventually learned to build on the positives in their relationship rather than fighting over the frustrations. Tough work, but compassionate openness can help develop the courage necessary.

Disappointment and frustration with what we feel

So far we have discussed how we can be disappointed in things and people that block our goals and affect our relationships. Another key area of disappointment centres around *our own personal feelings*. Some depressed people go to bed hoping that they will feel better in the morning, and it is a great disappointment when they don't.

Unfortunately, when depressed we often feel (understandably) disappointed and deflated when we wake up and don't feel any better but still anxious and tired. However, we can make matters worse by attacking ourselves, predicting that the day will go very badly and telling ourselves we 'should' be better. There are many other feelings that can be a source of disappointment. If this happens it can be useful to acknowledge this and engage in compassion under the duvet (see pages 151–2):

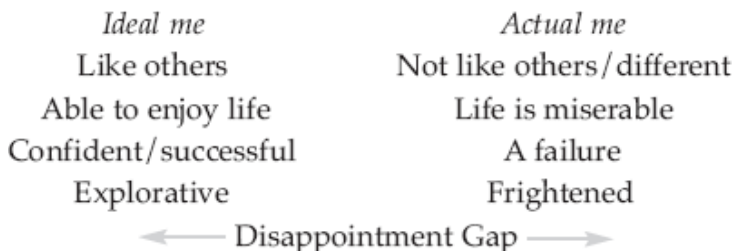
- When you first wake up, practise spending a moment to focus on your soothing rhythm breathing.
- Allow yourself to put on a compassionate facial expression. Don't worry if it seems odd or unnatural.
- Make a commitment to treat yourself with kindness today – to train yourself in this skill. If it feels very hard then that is a great opportunity for even a small bit of training to be helpful.
- Try not to fight with your thoughts or feelings, or force them to change, but notice them and be mindful of them as best you can.
- Keep in mind that feeling depressed is absolutely not your fault, it is sadly common and caused by many things.
- When you get out of bed and start to engage with the day go one step at a time, recognizing that you are doing the best you can. Make it a goal to be as supportive and encouraging of your efforts to cope with your depression as best you can.
- Some people prefer to get out of bed quickly without spending any time thinking about their thoughts or feelings. Again, practise and see which is best for you.

Let's widen our scope a bit and look at some examples relating to disappointments with feelings. The following problem shows clearly how difficulties can arise when our hopes and ideals are disappointed by our own feelings.

Don had suffered from anxiety attacks for many years and, as a result, felt that he had missed out on life. He developed a strong fantasy that, if someone could cure his anxiety, he would be 'like other people' and especially more like his brother who was successful in the art world. When I saw him, I found that his attacks were focused on a fear of being unable to breathe and of dying. However, by looking at the evidence that he was not going to die when he had an anxiety attack, and learning how to relax to gain more control over his attacks, he made progress. In fact, he did so well that he went on a trip to Europe. But when he came back, he went to bed, got depressed, felt suicidal and very angry.

We talked about the problem as one of unrealistic ideals. Don had the fantasy that if his anxiety was cured he would do a lot of things and make up for many lost years. In his fantasy, he would be like others, able to travel, be successful and, in his words, 'rejoin the human race at last'. He believed that normal people never suffered anxiety. He had hoped that there would be some magic method that would take the anxiety away, and that once it was gone, it would be gone for good. He explained that, on his European trip, he had suffered more anxiety than he'd expected.

We wrote out two columns that captured this situation, headed 'Ideal me' (i.e. without anxiety) and 'Actual me' (i.e. how I am now).



Our conversation then went something like this:

Paul: *It seems that you did quite a lot on your trip, but you feel disappointed with it. What happened when you got back?*

Don: *I started to look back on it and thought, 'Why does it have to be so hard for me, always fighting this anxiety?' I should have enjoyed the trip more after all the effort I put into it. I should have done more. It's been a struggle. So I just went to bed and brooded on how bad it all was and what's the point.*

Paul: *It sounds as if your experience did not match your ideal.*

Don: *Oh yeah, it was far from that.*

Paul: *Okay, what went through your mind when you found that the trip wasn't matching your ideal?*

Don: *I started to think I should be enjoying this more. If I were really better, I'd enjoy it more. If I felt better, I'd do more. I'll never get on top of this. It's all too late and too much effort.*

Paul: *That sounds like it was very disappointing to you.*

Don: *Oh yes, very, terrible, but more so when I got back.*

Paul: *What did you say about you?*

Don: *I'm a failure. I just felt totally useless. After all the work we've done, nothing has changed.*

Paul: *Let's go back to the two columns for a moment and see if I've understood this. For many years, you've had the fantasy of how things would be if you were better. But getting there is a struggle and this is disappointing for you. When you get disappointed, you start to attack yourself, saying that you're a failure and it's too late. That makes the 'actual' you seem unchanged. Is that right?*

Don: *Yes, absolutely.*

Paul: *Can we see how the disappointment of not reaching the ideal starts up this internal attack on yourself, and the more of a failure you feel, the more anxious and depressed you get?*

Don: *Hmm, yes.*

Paul: *Okay, it was a disappointment to have anxiety again. Were you anxious all the time?*

Don: *No, not all the time.*

Paul: *I see. Well, let's start from the other end so to speak. If you had to pick out a highlight of the trip, what would it be?*

Don [thinks for a moment]: *There were actually a few, I suppose. We went to this amazing castle set up on the hill . . .*

As Don started to focus on the positive aspects of his trip, his mood changed. He became less focused on the negatives and more balanced in his evaluation of the trip. I am not saying that you should simply 'look on the bright side' but suggesting you focus on the possibility that there may be some positives which offers some balance. It is easy to become focused on disappointment. By the end of the session, Don was able to feel proud of the fact that he had been to Europe, whereas a year earlier, going anywhere would have been unthinkable. He was not magically cured of his anxiety

disorder. The more he focused on what he could do, rather than on how much he was missing out or how unfair it was to have anxiety attacks, the less depressed and self-attacking he became. Learning to be more mindful rather than fighting with, and being angry with his anxiety might also have helped him.

You might also notice something else here. If somebody has had a problem like this for a long time, it can become almost built in to their sense of self, their self-identity. Don believed that he was victim to anxiety and had missed out on life. This sense of *being a victim* to his anxiety was very strong and not easy to give up. If people see themselves as losers it can actually be quite difficult for them to see themselves as winners because it is too different an identity. Sometimes we have to be honest with ourselves and think whether we are trapping ourselves in an old identity. Are we really confident that we would feel okay about being a happy person? Can we allow ourselves to be happy in spite of difficult life circumstances?

Disappointment with oneself

We can feel that we have let *ourselves* down because we have not come up to our own standards or ideals. Here again, rather than accept our limitations and fallibility – that maybe we have done our best but it did not work out as desired – we can get frustrated and then go in for a lot of self-attacking. It is as if we feel we can't trust or rely on ourselves to come up with the goods. We start attacking ourselves like a master attacking a slave who hasn't done well enough. This frustration with oneself can be a major problem.

Lisa wanted to be confident, as she thought her friends were. She wanted always to be in a good state of mind and never feel intense anger or anxiety or be depressed. She had two clear views of herself – her ideal and her actual self (Table 21.3) – and these would go hammer and tongs at each other. She felt lazy because she couldn't get motivated.

Lisa's ideal self and her actual self were unrealistic. Her ideal self could not be met much of the time. Her actual self (which she identified as her depressed self) was prone to discount the positives, think in all-or-nothing terms and overgeneralize. Much of this was powered by frustration and fear.

It may be true that we can't rely on ourselves always to be anxiety-free, or make the best of things, or be a mistake-free zone. The main thing is how we deal with our mistakes and disappointments. Attacking ourselves when we feel the anger of frustration is not helpful and, in the extreme, can make us very depressed. Learning to accept ourselves as fallible human beings, riddled with doubts, feelings, passions, confusions and paradoxes can be an important step towards compassionate self-acceptance. When disappointments arise, can we be understanding and compassionate? Anyone can be compassionate if it is plain sailing, but can you do it in a storm and when things are going wrong? That would be really helpful.

TABLE 21.3 LISA'S IDEAL–ACTUAL RELATIONSHIP

Ideal self		Actual self
Relaxed and confident		Fearful and anxious
Hard-working	← DISAPPOINTMENT GAP →	Lazy
Caring of others		Angry with others
<ul style="list-style-type: none"> • Attack self. Oh God, I've let myself down again. Why do I have to be so anxious all the time? Why don't I just get on and do things? I am a useless, pathetic person. • Attack others. Why do others always seem so confident? I hate them. They don't understand how difficult it is for me. • Give up. I had better not try too much because it will not work out. I'm bound to fail and let myself down. I just can't rely on myself. 		

A new baby

Fiona had wanted a baby for about three years. She would fantasize about how her life would be changed with a child, and she engaged in a lot of idealized thinking about smiling babies and happy families. However, the birth was a painful and difficult one, and her son was a fretful child who cried a lot and was difficult to soothe. She found it difficult to bond with him and, within a short time, became exhausted and felt on a short fuse. At times, she just wanted to get rid of him. She took such feelings not as a sad but not so uncommon experience of women after childbirth, but as evidence that she was a bad mother. When she could not soothe her son, she thought that he was saying to her, 'You're not good enough'. She thought that if she had been a better mother she would not have had a colicky child, and she would have been loving and caring from the beginning, regardless of her fatigue. She felt intensely ashamed of her feelings, and could not tell her family doctor or even her husband of the depths of her exhaustion or feelings of wanting to run away. She felt her feelings made her a bad person. The reality of life with her baby son brought a whole set of ideals crashing down around her head.

We can explore Fiona's ideal of her motherhood and her depression (Table 21.4).

TABLE 21.4 FIONA'S IDEAL–ACTUAL RELATIONSHIP

Ideal self		Actual self
Happy and relaxed		Tense and fraught; many sleepless nights
Feel loving towards my child	← DISAPPOINTMENT GAP →	Want to run away, feel aggressive
Be able to soothe him		He is difficult to soothe
<ul style="list-style-type: none"> • Attack self. I thought that I was a caring person but I feel so awful when he starts crying. I just want to leave him, to shut the door on him so I can't hear him. I can't cope, therefore, I'm a weak, inadequate and bad person. If people knew what was going through my mind, they would hate me, lock me up or take my son away. Maybe I don't deserve to be a mother. I hate myself for feeling this way. • Attack others. Why does my son have to cry so much? He doesn't like me. If he'd only sleep like a normal child, it would be better. It's not fair. Why do others seem so happy with their babies? I hate them. It's not fair. • Give up. There's nothing I can do. I should just passively accept this state of affairs or get away. No one could understand me. 		

Let's look at some kinder ways that Fiona might look at her situation, beginning with understanding and being compassionate to her distress. Here are some ideas for what she might reflect on and say to herself:

- **Compassionate understanding.** It's very understandable to feel upset about my baby's colic and how difficult it is to soothe him. That is indeed sad for me. Some women do seem to have an easier time of it. I was looking forward to this but in reality it is exhausting. It is understandable when you're exhausted like this to be on a bit of a short fuse and tearful.
- **Compassionate attention.** Although some women seem to bond easily with their babies, this is not true for all women by any means. Many women find babies who are difficult to soothe exhausting, and angry feelings are actually very common. Just like me. It's sad for them too. Lots of women's magazines write about these problems and they are also discussed on the Internet. It's clearly not my fault I'm having these difficulties and feelings. When I feel well I can be a caring person (bring to mind memories of caring).
- **Compassionate thinking.** There have been a lot of complex changes in my body and in my hormones as a result of childbirth and these can create all kinds of feelings in women, including myself. Many other women have these experiences too and so I am far from alone in this. If this happened to a friend I would be kind and understanding and see what help I could offer. Practising being kind and understanding to my distress is important too.
- **Compassionate behavior.** It will help me a lot if I face this problem honestly and discuss it with people who can help me, such as my health visitor or family doctor. They will be able to keep an eye on me and see if I need any extra help. I might also be able to talk to other women who have been in this situation and find out what has helped them. The most important thing is to say yes to the help on offer and not hide away in shame, because this is such a common problem for women.

The moment Fiona faces her sadness, stops attacking herself and recognizes that she is not alone but may need help, she is taking the first steps towards recovery. Becoming depressed after childbirth is intensely sad and disappointing, and you can experience many odd (sometimes even aggressive, overwhelmed or want-to-run-

away) feelings, but try not to be ashamed about them. To the best of your ability, be compassionate and kind with yourself, and reach out to others and discuss your true feelings with people around you and in particular your health visitor or family doctor.

One more point to keep in mind. If we're having feelings of intense disappointment, say, there is often some bright spark who tells us to pull ourselves together, or who seems able to cope with everything. It may be someone in our lives who is being very critical of us, or who likes to tell us how well they coped with things and who can make us feel that we are a failure by comparison. Don't be too influenced by these people (it might even be a parent). What we feel is what we feel, and rather than attacking ourselves, it is preferable to look at the ways we can cope and sort out our problems in the ways that best suit ourselves.

Overview

It is human to want to achieve certain things and create fantasies in our minds. However, these fantasies can become unrealistic because life is often complex and difficult. In this chapter we have noted how we can produce all kinds of fantasies and can create all kinds of hopes, anticipations and expectations. If these don't come to fruition we can be disappointed. In our fantasies we often live a life of excess. Living in the *reality* of life can be tricky, but if we learn to be kind and compassionate, mindful and understanding, these can help us get through. Frustration and disappointment are not in themselves bad – indeed learning that we can't have what we want when we want it is important for our maturity and wisdom.

KEY POINTS

- We can be disappointed with all kinds of things in our lives such as blocks to major life goals, relationships and personal feelings.
- Our anger and frustration or disappointment can set in motion a train of thoughts that are either self-attacking and/or other-attacking.
- If we can learn to identify these thoughts early, we can take steps to work against them and work through them.
- As the anger grows in us, there is a tendency to use many of the thinking styles we have met in earlier chapters (e.g., all-or-nothing thinking, overgeneralizing, disqualifying the positives, dwelling on the negatives – see Chapter 10).
- Although disappointments are always upsetting, we can perhaps learn to limit their effects on us and prevent them from driving us into depression.

EXERCISES

Exercise 1

Think of the last time you felt disappointed and angry about something. Then write down your ideal thoughts and your actual thoughts in two columns. Find out if you do any of the following:

- **Attack self.** Write down any self-attacking thoughts that have been produced by this disappointment.
- **Attack others.** Write down any other-attacking thoughts that have arisen from this disappointment.
- **Give up** in a hopeless, irritated sort of way.
- **Develop acceptance** and see what you might do to improve or move on.

Exercise 2

Now that you have worked out how you tend to react to disappointments, first acknowledge your anger. Ask yourself:

- Am I going in for all-or-nothing thinking?
- Am I discounting the positives? What remains good or okay?

- Am I overgeneralizing by saying that everything has been spoiled?
- What would I say to a friend who had this disappointment?
- What would I like someone who cares for me to say to me?
- Spend a few moments thinking about how you would actually like to be able to deal with frustration and disappointments – would that be worth training for?
- Create in your mind the self you would like to become.

Further things to try

Self-feelings and judgements

Distinguish clearly between your actions and yourself (see Chapter 13). For example, ask yourself: If I fail an exam, does this make me – a person, my whole being, my totality – a failure? I might feel like a failure, but this does not make it true. Are you saying, 'I only accept me if I do it well'? If you fail at something you may have that heart-sink feeling, but the key thing is how quickly you can recover yourself and be kind and help yourself through this disappointment in your life – getting through and coping is the aim.

Shoulds, oughts and musts

Explore the pressure of the shoulds, oughts and musts in your life and how they can produce more emotional pain. Work out your preferred compassionate ways to spot and tone them down.

Shame

Are you disappointed because somehow you feel ashamed at not meeting your ideals? (If so, look at the shame exercises in Chapter 17).

Reality check

Although it may be painful it can help if, in a friendly voice, you ask yourself, 'Are my ideals realistic?'

Compassion work

When we are frustrated or disappointed, compassion can be very helpful. As I have indicated above, what you can do here is to focus on your soothing rhythm breathing and then work through what you feel would be compassionate attention, thinking and behavior to help you with your setback and frustration.

It is helpful if you recognize that you will be upset by things – this is simply natural. However, what you're looking out for is whether your frustration or anger becomes destructive by attacking yourself or others, or you have the heart-sink that pulls you down. Again, don't blame yourself for having the anger but do be gentle with it and at the same time bring more kindness and compassion into your frame of mind.

When you run into a major setback, or even if you are struggling with small setbacks, it can be useful to write a **compassionate letter** (see pages 235–9). This can help to get things in perspective and create the kind, friendly tone. Don't forget, this letter will be focusing on compassionate attention, thinking and behavior and looking at your courage and abilities – things we often forget and underestimate when we feel bad.

Summing up

Depression is probably one of the darkest winters of the soul. Researchers throughout the world are trying to work out why we have this capacity to feel as terrible as we do – and many have come up with various explanations. We know that there are many different types of depression, with different causes and factors maintaining it. In this book, we have looked at some common types of depression. Whatever else we say about depression, it is clear that there is a toning down of the *positive* feelings and a toning up of our *threat*- and *loss*-based ones. The emotions of anger, anxiety and dread were originally designed to protect us. It is when they get out of balance that they can have unhelpful effects. One evolved protective strategy is to slow down and hide – try to recuperate. In depression, however, this ‘go to the back of the cave and stay there’ is not conducive to our well-being. Our energy takes a nose-dive, our sleep is affected and of course our thoughts and feelings about ourselves, others and the world we live in are dark. But fundamentally, depression is a brain state and brain pattern to make us lie low when things are stressful.

We now know that depression is a potential state of mind that has evolved over many millions of years. Many animals too can show depressed states. We also know that depression is very much linked to the support and acceptance of others and ourselves. We have evolved to be motivated to be wanted, accepted, valued and have status in our relationships. Depression is marked by inner feelings of being distant and cut off from others, with a sense of emotional aloneness.

What comes through from our understanding about depression, and many studies on our human needs, is that we have evolved to be very responsive to kindness – from the day we are born to the day we die. I outlined some of the evidence for this in Chapter 2. Kindness soothes the threat system and indicates helpful resources. This in turn reduces the ‘go to the back of the cave’ protection strategy. This is why it is so important to learn self-kindness, because your brain is designed to respond to it. Depression also relates to our desire to feel in control of our lives rather than controlled. Here are some key ideas.

- Depression is a very varied problem. It ranges from the mild to the severe. Some depressions are associated with much anxiety, others with much anger. Some come on slowly, others quite quickly.
- Accept your depression as a brain state that has been triggered in you rather than feel ashamed of it, fight with it, hate it or condemn yourself. Once you accept it then you are freed to work compassionately with it. You can then take the objective view that by working in a certain way you may be able to shift this brain state. It is about healing our minds.
- There is an important psychological component to every depression, which this book has focused on, but this does not mean that psychological change is all you need to

recover from depression. Some people benefit from medication and others require a change in social circumstances.

- Commonly, when we are depressed, we have problems in the way we think and experience ourselves and relationships. We may try to run from our painful emotions or ruminate on unhelpful emotions; our fears, moods and emotions take control over our thinking. Training our mind is a way of gaining control over it. But, like learning to ride a bike or do tricks with a football, it helps if we dedicate ourselves to the training.
- One key path of training is to make a commitment to develop one's compassion for self and others, and with this one's wisdom, emotional tolerance, strength and kindness. We can try to practise compassionate attention, thinking, behavior and feeling – each day!
- Compassion feelings can be difficult to experience because that system in our brain is toned down and/or we are frightened of it. It can feel overwhelming, or make us feel sadder; we may feel we don't deserve it or that we will let ourselves off the hook or become weak. So at first we need to work on compassionate thinking and compassionate behaviour. Think about compassion training as physiotherapy for your brain. It is then a question of step by step, working your exercises to increase your capacity to tolerate and feel compassion.
- Self-help books can be very useful, but of course sometimes we also need professional help. Self-help is no substitute for that. It may be that reading this book has encouraged you to consider whether you might benefit from therapy or other forms of help. If you think you might be depressed then contact your family doctor, who can talk things through with you, assess your symptoms and difficulties and if necessary refer you to a properly trained person.
- Shame can be one of the main reasons why you may be reluctant to seek help, but remember that depression is one of the most common problems that mental health professionals work with. You are far from alone. A similar case can be made for talking with friends; open up to friends, but choose people who you think will be able to understand you.
- Although you may need extra help, there are also many things that you can try to help yourself or at least avoid making your depression worse. To come back to my main point then, make a commitment to develop your abilities to be kind to yourself, able to reflect on your thoughts and your feelings using some of the ideas in this book, and engage in behaviors that have a chance to move you out of the depressed state of mind.

What is helpful?

Researchers are exploring what kind of self-help strategies depressed people find helpful. A review of this has recently been provided by two Australians, Amy Morgan and Anthony Jorm.¹ They broke these strategies down into three groups:

- 1 **Lifestyle strategies** include taking exercise, trying to maintain a regular sleep schedule, increasing activities that are potentially enjoyable (as opposed to boring or dutiful), and recognizing the need for resting. In general this means acting against the push and pull of depression and anxiety. Also important is body care, such as healthy diet and avoiding toxic substances such as drugs that have any influence on one's mood.
- 2 **Psychological self-help** includes focusing on rewarding oneself for small achievements, recognizing that many others suffer depression and visiting self-help websites (e.g., [beyondblue](http://beyondblue.org.au), www.beyondblue.org.au is a particularly good one), trying to break difficulties down into smaller problems, practising

mindfulness and monitor -ing one's thoughts.

- 3 **Social strategies** include trying to open up to other people, joining support and hobby groups and talking to somebody who has been through depression.

Interestingly, these researchers do not mention the importance of learning compassion to balance one's mind. Although the Buddha recommended this nearly 3,000 years ago we are only beginning to recognize its power. When you engage in any of these self-help strategies, do it in the spirit of self-support, kindness and compassion.

In addition, think about regularly exercising your brain in the ways described in earlier chapters. There is increasing evidence now that practice may change your brain over time.² However, like playing the piano or golf, you wouldn't expect to be good at it first time out. Regular practice, however, will improve your abilities. It is the same with compassion.

Keep in mind also that your compassion practice will have three components (see Chapter 8):

- 1 opening yourself to compassion from others (including the use of imagery)
- 2 compassion that you practise for others
- 3 compassion for yourself.

However, we have also looked at the way we can train our minds, direct our attention, thinking and behavior in a compassionate way which is conducive to healing depression; changing the brain state of depression from one of low positive emotion to more balanced emotion.

Don't get lost in unanswerable questions

When depressed we can feel life is meaningless – we are just oddities on a far-out planet; jumped-up DNA. Try not to get lost in this because 1,000 years from now we will see ourselves very differently. Many scientists are trying to answer the big questions: Why does the universe exist at all, rather than nothing? How can life evolve and why does consciousness exist? What is the meaning of life? We have no good answers! Your dog will never understand or be aware of existing in a material universe with planets. It will not have any notion of how your mind can think – because yours is so *different*. So there may be things way beyond our comprehension too, because our brains are limited. Don't set yourself unanswerable questions. We simply cannot answer a question about ultimate meanings in a life process. Rather decide what gives life meaning for you in *this lifetime*; you may or may not have other lifetimes or types of consciousness. All you can do is focus on this life – right here, right now. Trying to understand your mind and learning the art of compassion for self and others might not be so bad a goal to make life meaningful. Certainly the depressed mind state is the last place you should look for answers to complex questions.

Ten key steps that may help

- 1 Seek help if you need it, don't suffer in silence.
- 2 Go step by step.
- 3 Break problems down into smaller ones, rather than trying to do everything in one go.
- 4 Introduce more positive activities into your life.
- 5 Become more attentive and aware of your thinking and the ideas that go through your mind when you are depressed.
- 6 Identify your typical thinking styles (e.g., all-or-nothing thinking, discounting the positive aspects of your life). Note especially what you think about yourself, and how you label and treat yourself. Look out for your internal bully. Remember that this can drive you further into, rather than out of, depression.
- 7 Write down your thoughts to aid clarity and to focus your attention.
- 8 Identify the key themes in your depression (e.g., your need for approval, shame, unhappy relationships, unrealistic ideals, perfectionism). This will allow you to spot more easily your personal themes when they arise – and to challenge them.
- 9 Learn to work on your thinking with the use of your rational/compassionate mind. The more you treat yourself with compassion and give up thinking of yourself in terms of inferior, bad, worthless, and so on, the easier it will be for your brain to recover.
- 10 Try to work on negative thoughts and developing new ways of behaving. However, also expect setbacks and disappointments from time to time.

Finally, remember:

- Your depression may be a state of mind you are in, but your depression is not you.
- Your anxiety may be a state of mind you are in, but your anxiety is not you.
- Your anger may be a state of mind you are in, but your anger is not you.

These states of mind are to do with how your brain was designed over millions of years. They are part of human nature.

Whatever judgements of 'you' that your emotions come up with, they are about as reliable as the weather. The more compassionate you are with yourself, the less you will be a 'fairweather friend' to yourself. If you can stay a true friend to yourself, even though depressed, you are taking a big step forward. You're on the way up

Bringing the themes of compassion practice together

Over the next few pages you will see some worksheets that are designed to help you focus on different aspects of compassionate self-help. In essence we are bringing together many of the ideas we have discussed throughout this book. We've covered quite a lot of ground, so when you look at the worksheets you may feel they are a bit overwhelming. Don't worry, however, just follow them through as best you can. You'll see that they make some logical sense. The key always is to focus on what you think would help you.

Developing your compassion practice

The worksheets at the end of this chapter help you work with specific events and practice. When we are distressed we want to find ways to work with that stress or upset without making it worse. This means we need to think about our attention, how we approach the upset, how we think about this and behaviors to try and deal with it.

This worksheet offers various prompts and ideas designed to help you to practise refocusing your mind and accessing your soothing/contentment system. When threatened or upset, it's easy to become focused on unpleasant feelings, worries or memories. Recognize them, but also rebalance your system.

Remember the depressed mind will pull our attention and thinking towards loss and threat. We have to make a commitment to focus, think and act against our urges to do nothing, to avoid things, or to dwell on the unhappy things.

Keep in mind that this can be hard and stay as kind and compassionate to yourself as you possibly can – no matter how well or poorly you think you do with any of the following.

One important aspect of practice is how to do it. Probably the best way to begin is to start in small steps, or as big steps as you feel able. We can begin with what we called on pages 151–2 'compassion under the duvet'. This means that before you go to sleep and when you wake up spend some time focusing your mind on your soothing breathing rhythm, adopting a kind and friendly facial expression, and creating your compassionate self. The act of imagining that you are this self can be helpful. Of course when we are depressed it can be extremely difficult to get any feelings, or even to bother. However, it is the effort and focusing your mind on compassion that matters. Don't worry if your mind constantly wanders – just bringing it back again is helpful. Try it for a week and see how you do. If you prefer, you can engage with your compassionate image.

Doing this for a couple of minutes each day (more if you can) might be enough to get you going. What you may find is that you become more aware of the possibility of compassion. When you're at a bus stop, on a train or in the bath, or anywhere where your mind can run free, you might consider slowing your breathing down and then focusing on a compassionate exercise. Imagine what's happening in your brain each time you do this. Imagine that those areas of your brain that are conducive to well-being and recovering from depression are being stimulated. As you get more into that practice, you may want to spend more and more time on it. For example, you might put aside 20 minutes or even longer each day, or a few days a week to focus on mindfully developing the feelings of compassion, practising directing compassion to others and to various parts of yourself. It's useful to keep a journal so that you can see your practice developing over time. You may want to find other groups or retreats where you can take this further.

Keep in mind that we often *bring compassion into life through action*. For example, someone who is frightened of going out of the house will need to confront that fear at some point by going out. They are more likely to develop the courage to do this if they can attend to a kind, supportive and understanding voice in their head rather than the critical or panicking one. It is the same with depression. We are more likely to be able to develop alternative thinking, accept ourselves and our emotions, and act against our depression if we learn to attend to a kind and supportive voice in our heads rather than critical or pessimistic ones.

So it has been a long journey. Depression can indeed indeed be a dark night of the soul but with practice and compassion we can begin to light a few candles. May your

compassion grow with you. We wish you well.

WORKSHEET 1: COMPASSIONATE IDEAS TO COPE WITH LIFE DIFFICULTIES AND UPSETTING EMOTIONS

Record your regular practice, choosing an activity

Compassionate attention

Compassionate attention is about our focus and how we create images and recall helpful memories:

Engage and attend to your soothing breathing rhythm (see Chapter 3)

Adopt a compassionate body posture and facial expression.

Become mindful – hold your attention ‘in this moment’ rather than becoming distracted by ‘what ifs?’ and ruminations (see Chapter 7).

Recall times when you’ve coped.

Recall times when you were happy.

Focus on your compassionate image.

Keep in mind that things and feelings change.

Create an image of yourself coping or of you at your best.

Imagine yourself having got through this difficulty – and really focus on that.

Observe thoughts and feelings as patterns created in you – and realise that you can experience many different patterns.

Compassionate thinking/reasoning

Compassionate thinking/reasoning is about how we think things through – the kinds of self-talk and conversations that go through our minds.

Notice if you’re minimising and decide to move out of it.

Notice if your feelings or thoughts are self-critical and decide to switch to a kinder and compassionate focus (see Chapter 13).

Imagine yourself as a compassionate person speaking to a friend. Actually speak out loud with a warm voice tone. Listen to yourself offer coping and helpful ideas (see Chapter 8).

Put yourself in compassionate self mode and feel compassion for your upset self. Stay in that compassion mode.

Compassionately speak to your upset self, if it helps, place a hand just over your heart area. Bring as much wisdom, strength, warmth and noncondemning to this as you can.

WORKSHEET 1 (continued)

Record your regular practice, choosing an activity	Reflections on what helped, what was difficult and what requires practice
<p>Bring to mind your common humanity and become aware that many humans can struggle with difficult feelings.</p> <p>Feel at one with them rather than alone or different.</p> <p>Recognize how often some of what you feel and especially depression isn't your fault. Focus on the reasons why it isn't (e.g., we did not design our brains or backgrounds).</p> <p>Assume that others will be helpful until you get evidence that they won't.</p> <p>Keep in mind the motto: 'The secret of success is the ability to fail.'</p> <p>Focus on your efforts rather than on results.</p> <p>Compassionate behavior</p> <p>Compassionate behavior is behavior that will help you cope with your difficulty.</p> <p>Make a commitment to behave in ways that help you move forward in life, even if this means short-term difficulty.</p> <p>Practice trying out different behaviors and see which ones work for you.</p> <p>Decide to act against your depressive feelings and try to do more.</p> <p>Commit yourself to trying (or even for a short while) some anti-depressant behaviors (see Chapter 12).</p> <p>Do a little (more if you can) thing you will be pleased with.</p> <p>Reach out to others and see if help is available for you.</p> <p>Keep in mind that confidence develops from engaging with the difficulty, and that this trying time you are going through now may, in the long term, build your confidence.</p> <p>Recognize your limits, and when you need to rest, slow down or take time out.</p> <p>If problems seem large, try to break them down into smaller elements.</p>	
<p>Compassionate feeling</p> <p>Whatever you attempt to do, always try your best to do it with kindness so that you feel your efforts to be ones of support and encouragement, in the service of helping yourself cope and flourish.</p> <p>Remember that coping can be hard and can take practice. There are no oughts or shoulds here, no perfect ways to cope, no finishing or riding oneself of difficult feelings — just basic kindness for the difficulties that many of us find ourselves in. This won't remove those difficulties but it might ease your path through them — good luck!</p>	

WORKSHEET 2: COMPASSIONATE PRACTICES

Record your regular practice, choosing an activity	Personal comments and reflections on your practice
<p>Soothing breathing rhythm and mindfulness: being 'in-the-moment'.</p> <p>Practise looking at things in new ways, noting the things you enjoy and can savour, no matter how small – e.g. the first cup of tea of the day, the warmth of a bath.</p> <p>Consider things you are grateful for in joyous, fun ways, no matter how small. Even noting the first cup of tea of the day or the smell of coffee.</p>	
<p>When in a place of quiet, focus on your ideal compassionate/caring image. It has the qualities of wisdom, strength, warmth and non-judging/condemning and gives these unconditionally to you, with the deep desire for you to flourish and be free from suffering.</p> <p>Practise feeling that flowing into you from your image. Remember that images can be fleeting and more felt than seen. Your image is well aware of how difficult our evolved brains/minds and lives can be for us.</p>	
<p>When in a place of quiet, focus on feeling yourself to be a compassionate person with the qualities of wisdom, strength, warmth and non-judging /condemning – which you direct unconditionally towards yourself.</p> <p>Also practise directing compassionate feelings towards others. In both cases (directing towards yourself and towards others), focus on the deep desire for you and others to flourish, be happy and free from suffering.</p>	
<p>Compassionate behavior: choose and enact compassionate behavior that has the intention and deep desire for you and others to flourish and be free from suffering. This may include letter writing or acts of appreciation or gratitude or courageously doing something you are fearful of but would like to overcome. Make a commitment to look after and take care of yourself, as you would a dear friend. Seek out ways to learn assertiveness if you feel this would help you.</p> <p>Express your appreciation to others. Make a point of trying to be kind to others and see how you feel when doing that. Pay attention to how different things you do affect your feelings. If you're in conflict with someone or something, work on the most compassionate and helpful (non-submissive) way forward. Note any novel ways you have found to develop your compassion-focused lifestyle.</p>	

Appendix 1

Monitoring and balancing your thoughts

These forms and how to use them are explained in Chapter 11.

Using Thought Forms

Chapter 11 introduced the idea of thought forms to help you monitor and record your key thoughts and to practise generating a helpful alternative. At the end of the book you will find some blank forms for your own use (and you can photocopy them). You will also find some worked examples. Although the forms may look somewhat complicated, they are fairly straightforward when you get the hang of them. Remember, as we said in Chapter 11, you can use a form that simply has two columns, one to record your negative thoughts and one to record your helpful alternative. The thought forms here have five columns, which are used as follows.

- **Column 1.** In this column write down any situation(s), event, memory, feeling or image that has sparked off feelings of anger, despair or depression, etc.
- **Column 2.** Where it says ‘Beliefs and key thoughts’, ask yourself some questions, such as how are you seeing this event? What is going through your mind? What are you thinking about yourself? (For example, are you telling yourself you are no good?) How do you think this event affects your future? What do you think other people are thinking about you? All these questions are designed to explore your key beliefs, those thoughts that can make you feel sad, down and upset, etc.
- **Column 3.** In this column (the ‘Feelings’ column), write down what your feelings are/were and how intense they were. The reason we put the feelings in the third column is so you can see how your thoughts link the situation with your feelings – like a bridge between the two. (You may want to fill in this column before column 2.)
- **Column 4.** In this column, labelled ‘Compassionate alternatives to depressive thoughts’, stand back and think what you might say to a friend who had these negative ideas. Can you think of evidence of why your depressing thoughts may be a bit distorted? Can you think of evidence against your negative thoughts and beliefs? What alternatives might there be? How might you best cope with this? What kinds of ideas would be helpful here? Again, it is helpful to get the idea that you are not going to accept your depressing thoughts simply because your feelings of depression tell you to.
- **Column 5.** When you have taken some time to compassionately refocus your

thinking, look at what you have written down and see if this has changed your feelings. If so, write down how much your feelings might have changed about that event now. Focusing on this possible change may give you an opportunity to see that by stepping back from your thoughts, you can change your perspective and feel better.

Some people like to read what others have written and ways they have challenged their thoughts, but don't just write out *their thoughts*. Do it yourself – with your own thoughts. Try it out – after all what have you got to lose?

Compassionate working

Remember that one of the main reasons for working on your thoughts is to help you *feel* differently about things and, in particular, not add to your stress. It is important to approach this with as much warmth and understanding as you can manage. Your alternatives should not be cold, bullying or irritable in their emotional tone. The more you learn to have sympathy with yourself, while at the same time looking at the helpful alternatives, the easier you may find it to change your feelings.

So, let's look at the forms now. The first form will provide you with some single (one-line) or basic example. Get the hang of this first and then you may wish to have more of a dialogue with yourself. Forms 2, 3 and 4 offer more complex examples for generating compassionate alternatives. I have also put in possible ratings for degrees of beliefs and feelings, which you may find useful.

THOUGHT MONITORING AND CREATING HELPFUL ALTERNATIVES: EXAMPLE 1

Triggering events, feelings or images Key Questions to help you identify your thoughts. What actually happened?	Beliefs and key thoughts What went through your mind? What are you thinking about yourself, and your future? What are you thinking about others?	Feelings What are your main feelings and emotions? Rate degree of feelings 0–100	Compassionate alternatives to depression thoughts What would you say to a friend? What is the evidence against this view? How would you see this if you were not depressed? What would your compassionate friend say? Rate degree of belief in alternatives.	Degree of feeling change Write down any degree of change in your feelings.
Example 1 Friend at work snubbed me.	Rate degree of belief 0–100 He/she doesn't like me. Sees me as inadequate. 70%	Upset, hurt, angry. 60%	Probably nothing to do with me at all. My friend can be quite moody and I have seen him/her do this to others. 50%	20%
Example 2 Forgot to take important file to work.	This is typical me. I am useless and a failure. 80%	Frustrated. Angry. 90%	It is understandable to feel frustrated because it will hold up my work today. However, this does not make me useless. I won't even remember this event in three months' time. Accept my frustrations, practise compassionate self-forgiveness and focus on what I need to do now – what is helpful in this moment. 70%	40%
Example 3 Just feeling down today.	I am always going to be depressed. Nothing will ever work for me. 70%	Depressed. Fed up. 80%	Moods do go up and down. This is typical and is not my fault. I have better days than today. I am disappointed but I can see the sense of working with my thoughts, and in my heart I know if I keep going I'll feel better. 30%	20%
			Compassionate focusing Now read all the above through slowly but this time just focus on creating as much warmth, kindness and support rather than trying to convince yourself of the alternative. See what happens when you do this.	

THOUGHT MONITORING AND CREATING HELPFUL ALTERNATIVES: EXAMPLE 2

Triggering events, feelings or images Key questions to help you identify your thoughts What actually happened?	Beliefs and key thoughts What went through your mind? What are you thinking about yourself, and your future? What are you thinking about others? Rate degree of belief 0–100	Feelings What are your main feelings and emotions? Rate degree of feelings 0–100	Compassionate alternatives to depression thoughts What would you say to a friend? What is the evidence against this view? What would your compassionate mind say? How would you see this if you were not depressed? Rate degree of belief in alternatives	Degree of feeling change Write down any degree of change in your feelings.
Too much work to do.	I can't get it all done. I will never succeed. Others can do more than me. I am incompetent and a failure. 80%	Depressed. Fed up. 80%	Depression often makes us feel like this, which is very hard. Let me just slow down a moment and take a breath for moment or two and focus my mind. Key thing is to focus on one thing at a time rather than 'everything' to do. Kind of like don't down look if you're climbing a ladder – just go step at a time. I have actually managed to do things when I have taken this approach My problem is my depression, which takes off my energy making it hard to engage. It is absolutely not about being a failure – many millions feel like I do. It is important to also try to see if I can do something I would enjoy no matter how small – even having a cup of tea – and focus on the pleasure of that. Just steady as we go. Noticing but, to the best of my ability not reacting to my critical or pessimistic thoughts.	20%
			Compassionate focusing Now read all the above through slowly but this time just focus on creating as much warmth, kindness and support rather than trying to convince yourself of the alternative. See what happens when you do this	

THOUGHT MONITORING AND CREATING HELPFUL ALTERNATIVES: EXAMPLE 3

Triggering events, feelings or images Key Questions to help you identify your thoughts: What actually happened?	Beliefs and key thoughts What went through your mind? What are you thinking about yourself, and your future? What are you thinking about others? Rate degree of belief 0–100	Feelings What are your main feelings and emotions? Rate degree of feelings 0–100	Compassionate alternatives to depression thoughts What would you say to a friend? What is the evidence against this view? What would your compassionate mind say? How would you see this if you were not depressed? Rate degree of belief in alternatives.	Degree of feeling change Write down any change in your feelings.
Argument with partner	I am going to end up rejected. It's all my fault. I must be very unlovable.	Depressed 75%	That is distressing, but it is. However, let's take a soothing breath here and refocus. My fear of rejection is probably what is behind this thinking, so hold on. There are problems in the relationship, but I can't take all the blame (see pages 284–6). There are things that we are both unhappy with and need to sort out. If I take the blame then we can't work together. Self-blaming makes me depressed which actually stops me from trying to make the relationship work. It is upsetting to have arguments, but if I avoid all-or-nothing thinking about my lovability I am more likely to see them through. Anyway, I have friends who like me, and we have had good times together in the past, so I can't be as bad as I am painting myself. 60%	30%
			Compassionate focusing Now read all the above through slowly but this time just focus on reading as much warmth, kindness and support rather than trying to convince yourself of the alternative. See what happens when you do this.	

THOUGHT MONITORING AND CREATING HELPFUL ALTERNATIVES: EXAMPLE 4

Triggering events, feelings or images	Beliefs and key thoughts	Feelings	Compassionate alternatives to depression thoughts	Degree of feeling change
Key questions to help you identify your thoughts. What actually happened?	What went through your mind? What are you thinking about yourself, and your future? What are you thinking about others? Rate degree of belief 0-100	What are your main feelings and emotions? Rate degree of feelings 0-100	What would you say to a friend? What alternatives might there be? What is the evidence against this view? How would you see this if you were not depressed? Rate degree of belief in alternatives.	Write down any degree of change in your feelings.
Children need clean clothes, ironing not done, just too many demands on me.	I can't cope with the needs of my family. I just want to run away and leave it all behind. Can't be bothered with them. I must be a selfish, cold person for feeling this way. If I was a better mother I wouldn't feel like this and would do more. 80%	Overwhelmed. Guilt. Depressed. 80%	To be honest, I am feeling exhausted right now which is understandable given the demands on me. I need to create more space for myself, take some time out for myself if I can, and ask my family to help out more. I can break my problems down and just focus on things I can cope with. I can prioritise and see how I can focus on the key things. The desire to escape is a natural and normal feeling when one is exhausted and is not evidence of being a poor mother, indeed many mothers feel like I do from time to time. Okay let's go step at a time and see how we do. 60%	20%
			Compassionate focusing Now read all the above through slowly but this time just focus on creating as much warmth, kindness and support rather than trying to convince yourself of the alternative. See what happens when you do this.	

Appendix 2

Quick guides

Identifying your thinking style

To *identify* your threat- and loss-focused thinking style, pay attention to your feelings (see Chapters 9 and 10). Then ask yourself:

- What is/was going through my mind?
- What is/might be my underlying threat – may there be fear or sense of loss here?
- What am I thinking about me?
- What kind of judgements am I making about myself?
- What judgements or assumptions am I making about other people?
- What am I thinking about my future?

The way you think about things can affect the way you feel. Below is a summary of some typical ways of thinking that can worsen depression. This is a brief summary of what was discussed in Chapter 10. If you can learn to spot these styles of thinking in yourself, it can be a helpful first step to pulling back from them, taking the view from the balcony, and trying to bring balance to one's thinking. We all use these styles of thinking from time to time; no one is 100 per cent logical or compassionate all the time. But in depression they are taken to extremes.

- **Jumping to conclusions.** This involves the tendency to make decisions rapidly, especially when under stress. For example, you might jump to the conclusion that someone does not like you because they ignore you. You may predict the future, e.g., that nothing you do will work out. Jumping to conclusions means that you don't look at the evidence. Instead, you go for immediate gut reactions and assume these to be true.
- **Emotional reasoning.** This involves an over-reliance on feeling to guide judgements, for example, 'I feel this is dangerous, therefore it is', or 'I feel I am stupid therefore I am', or 'I feel unlovable or unattractive therefore I am'. You assume that negative feelings reflect the way things actually are: 'I feel it, so it must be true'. Feelings are often poor guides to reality. The 'power' of feelings comes from our more primitive brains having more control than is often good for us. Remember to test out feelings: look for alternatives and explore the evidence for and the evidence against. Does it pass the friend test – is it something you'd be happy to say to a friend?
- **All-or-nothing thinking.** This is also called 'black-and-white' or 'polarized'

thinking. We see things in ‘either/or’ categories. If our performance falls short of what we wanted, we see it or even ourselves as a total failure. We may think: ‘Either X loves me or s/he doesn’t’, or ‘Either I succeed or I fail’. However, life is full of indeterminate areas. Love is not either/or; there are degrees of love. Success is not either/or; there are degrees of success. It is more useful to think of the degree of success rather than the degree of failure. It is always worth thinking if there is a sense of threat, fear or loss that might be driving this all-or-nothing thinking. If so, consider some of the ideas I have offered to become compassionate to your fears and balanced in your thinking.

- **Overgeneralizing.** This is when we take a single negative event and see it as a never-ending pattern of defeat. Here, one swallow does make a summer. We may think that things can never change, or that one failure means that everything one has done was a failure or faked. Think back and ponder if you tend to think like this and it turns out to be wrong. Is this style of thinking linked to your frustration or fear? If so, consider some of the ideas I have offered to become compassionate to your fears and balanced in your thinking.
- **‘I must’.** These thoughts involve feelings of being compelled to do something. ‘I must be in a relationship to be happy; I must achieve things to be a worthwhile person; I must never be criticized; I must never fail.’ Turn musts into preferences, for example, ‘I would like to do this, but if I can’t then it does not mean that I am a no-good person or that I can’t be happy.’ The typical helpful thing here is to learn to accept feelings as they are. We can turn ‘musts’ into preferences. It’s not quite as good as turning water into wine, but it helps.
- **Emotional tolerance.** Telling ourselves that our emotions are intolerable and we must get rid of them is usually a recipe for problems. We have emotions because our brain is designed to create them in us – and pretty powerful they can be, too. The key here is to be mindful and to observe them (watch your evolved brain at work) then engage in compassion for them and for you going through them. Consider how you can be like the rock when the wind blows, you are solid – how might you develop this ability? Look out for threat-focused thinking related to your emotions; desire to be able to tolerate emotions (see pages 208–13).
- **Discounting and disbelieving the positives.** This involves the tendency to ignore or dismiss positive attributes, events or achievements. You either take them for granted or think ‘anyone could do that’. When you disqualify the positives it is difficult to get started on the way up. Focus on what you can do rather than on what you can’t. Usually we are frightened to trust in the positives, so it is worth thinking about your fear of the positives and then practise compassion for the fear – see your ‘fear of the positives’ self in front of you and be compassionate to it – balance your ‘thoughts’ – try allowing a bit of positive, and build up.
- **Discounting and disbelieving others.** This involves things like thinking that other people’s (good) opinions of you don’t count. You think that either they don’t really know you or you have kept things hidden and deceived them. At other times you may think that others only say positive things to be nice; they don’t, in their hearts, really mean it. This often involves a loss of trust. Think about if this is a bit of black-and-white thinking – maybe they know you a bit and like that bit?
- **Amplifying the negatives.** When we’re depressed it is all too easy to dwell on negatives and difficulties. They take on more importance and we are very attentive to possible rejections, put-downs or failures. We can easily lose perspective by

amplifying negatives and dwelling on them. Regain perspective by generating alternatives. Keep in mind this is not your fault because it is how your evolved brain and threat self-protection systems are designed to think in terms of 'better safe than sorry' and 'assume the worse'. Therefore we need the balance of our rational and compassionate self.

Recognizing your self-attacking thoughts and styles

- **Self-criticism.** This is when part of us becomes like an observer and a judge. We're constantly passing negative judgements on ourselves, as if a critical parent were sitting on our shoulder. We're more focused on what we do wrong or badly, rather than on what we do well. Practise the art of compassionate self-correction (see Chapter 13).
- **Personalization and self-blaming.** This involves the automatic tendency to assume that we are in the wrong or are responsible for negative events. We may not look at the evidence or consider alternatives, or reflect that most things are caused by a number of different factors (see Chapter 13).
- **Self-labelling.** This involves 'all-or-nothing' thinking about yourself as a person. If your behavior fails, you think you are a failure, unlovable or inadequate, etc. In depression this type of thinking involves blaming and name-calling (e.g., I am useless, inadequate, weak, a nuisance, a fake, worthless, bad, etc.). Refocus on taking a broad perspective and compassionate alternatives.
- **It-me.** This involves the tendency to judge ourselves rather than our behavior. We think that only our behavior matters; if that is not good, then we are no good. But behavior and self are quite different. A self is a conscious, feeling being, with hopes, desires and wishes. A behavior is just a behavior, that may or may not be disappointing. The trick here is learn to see that the emotions of frustration might confuse you into believing you are the label.
- **Self-attacking.** This involves a degree of anger and hostility directed at yourself. It is more than being critical – after all, not all criticism involves hostility, but in self-attacking one is hostile with oneself. Sometimes this part is frightened that if it doesn't criticize then you won't achieve anything. It is really fear-based. If we see that, then we can change our feelings about it. We can be compassionate to the fear. You can teach it compassionate self-improvement (see Chapter 13). Rather than dispute or argue with your self-criticism (although you can if it helps you, of course), engage your compassionate self and feel it expanding in you – in a way you are becoming bigger than the self-critical part (because it is only a part of you). Then feel compassion for it. If it shrinks, note that it's grateful to be released from critiquing. If nothing happens, or it seems to grow too much for you, then let the image fade and pull back to compassionate self-focusing, until you have stabilized again and are ready to have another go.
- **Self-hatred.** This is an extreme form of self-attacking. It is more than just anger with the self and often involves judgements and feelings of being bad, evil or disgusting. Unlike self-criticism, which aims to improve through punishment, self-hatred can be about wanting to destroy and get rid of the self. Rather than dispute or argue with your self-hatred (although you can if it helps you, of course), engage your compassionate self and feel it expanding in you – in a way,

you are becoming bigger than the self-hatred part (because it is only a part of you). Feel compassion for it. If it shrinks, note that it's grateful to be released from hatred. If nothing happens or it seems to grow too much for you, then just let the image fade and pull back to just compassionate self-focusing – until you have stabilized again and are ready to have another go. In this way you are slowly desensitizing yourself to your self-hatred.

- **Social comparison.** Although we all compare ourselves to other people, try to become more aware of when you do it. Check out how your mood changes and ask yourself if the social comparison is valid. Does it help you? Are you engaging in envious thoughts? Do such thoughts help you? Explore some compassionate ways to balance it.

Once you have identified your depressing thoughts, consider that you are now going to come at them with compassionate attention, thinking, behavior and feelings. Have a look at some of the worked examples in Chapter 9. Remember, too, they have to pass the friend test: would you recommend them to someone you care for or a child you love?

Appendix 3

Making your own flash cards

Throughout this book I have offered ways to generate compassionate alternatives for some of our depressing thoughts. Here are some ideas you could write down on flash cards (see Chapter 15) to deal with common depressing ideas and feelings. You might want to choose a card with a soothing picture.

I am weak to be depressed

- Depression is a horrible state to be in, but it is not evidence of weakness.
- Depression affects animals and humans because it is brain state made possible by the way our brains have evolved, therefore it is not my fault.
- Depression is a state of mind. Just as I can have other states of mind (e.g. happy, relaxed, angry, anxious), I can be depressed.
- Depression is unpleasant, but sadly many millions suffer from it because to the brain this is just one of its patterns for feeling.
- Depression can affect anyone – even people who are often regarded as strong (e.g. Winston Churchill).
- Depression is most often about becoming exhausted, trying too hard, feeling defeated, losing hope. Often there is something threatening us in our depression.
- By understanding it more, I can try to bring my rational/compassionate mind to help tackle it.
- There may be very real problems in my life that have exhausted me and made me vulnerable to being depressed.

If I need an antidepressant drug it means I am weak

- Depression is not about weakness, but can be about being exhausted.
- I need to get the evidence of whether an antidepressant would help me. If it can help me sleep better and boost my mood and confidence, then that might help me to get on top of my depression.
- Millions of people take antidepressant drugs.
- Whether I choose to take an antidepressant drug or not is my own decision. I don't need to prove that I can cope without one as some kind of test of my strength.

If I need some therapy I might have to reveal my anger or shame

- It is understandable to be anxious about revealing personal things to someone else, like a therapist.
- Properly qualified therapists are well aware that it is the things we are ashamed of that cause us problems.
- I have no evidence that a therapist will look down on me if I talk about the things that I am ashamed about. Indeed, just as a surgeon expects to deal with blood and guts, so therapists expect to deal with the less pleasant sides of life.
- The more I am prepared to face up to what I feel ashamed about, the more I may get to know myself and learn how to let things go, or see them in a different way.
- A therapist can't force me to talk, so I can go at my own pace and decide whether the therapy is helpful.

I can't do what I used to do, therefore I am a failure

- I am depressed right now, so it's natural not to have my normal drive.
- Even though I can't do what I used to, I can still do some things.
- I can praise myself for what I do do, rather than attacking myself for what I don't do.
- There is no way I am going to bully myself out of depression.
- I can go step by step.
- By praising my steps, no matter how small they may be, I am moving forward.
- My task now is to try to develop a kind and compassionate approach to tackling this depression.

I am worthless

- To sum up a person (e.g. myself) in simple terms of good–bad, worthwhile–worthless, is all-or-nothing thinking. 'Kind of' unkind too.
- Just because I feel stupid and worthless this does not mean that I am.
- If I over-identify with feelings of worthlessness then I am more likely to get depressed.
- The idea of worth can be applied to objects like cars or soap powder, but not to people.
- If I say 'worthless' is just one of a number of possible feelings that I, as a human being, can have about myself, then I can keep a perspective on these negative feelings.

I am so filled with anger I must be bad

- Anger is, like other feelings, something we are all capable of.
- High levels of anger usually point to high levels of hurt or vulnerability.
- My anger tells me that there is something I want to change and push against.
- True, flying into rages is not helpful, but I can learn to be more honest with my own needs and put them assertively.
- I can learn to understand my anger rather than just labelling myself as bad and trying to push my anger away.
- Maybe I can learn compassionate acceptance of my feelings and then slowly work to see how I want to act on them.

I am not as competent as other people, therefore I am a failure

- It is natural to want to compete in the world and feel that we are up there with others.
- All human beings are unique and need to go at their own pace. Just because some people seem more able than me does not make me a failure. I dare to be average or even less. Just 'doin' me best'.
- I can focus on what I can do and what is important to me, in my own unique life, rather than on what others are doing.

Nothing ever seems as good as I want it to be, therefore there is no point in trying

- Disappointment is part of life and I can learn to cope with it if I keep it in perspective.
- I can learn to focus on what I do get out of doing things rather than how far short they fall of my expectations.
- I can practise the appreciation exercises and see how I go.
- I can check out whether I attack myself when I am disappointed and learn how to be kinder with myself.
- This type of thinking is rather all-or-nothing. Therefore I can learn to focus on what I enjoy rather than on what I don't. It's the old story of the glass as half empty or half full – happiness lies in seeing the half-full bits of life.

I will never get better

- After reading this book, I realize that there are many ways to tackle depression and these work for many people (e.g. drugs, psychotherapy, family therapy, and various forms of self-help etc.).
- I don't have to suffer in silence.
- If I need extra help, I can talk to my family doctor and see what is available.
- I haven't always been depressed, so depression is a state of mind that I am in right now, but this does not mean that I'll always be depressed.
- I may have been trying to deal with my depression but, as this book points out, maybe I have been enduring it, trying to soldier on, rather than really tackling it.

Appendix 4

Useful resources

Books and CDs

DEPRESSION

- Brantley, J. (2003). *Calming Your Anxious Mind: How Mindfulness and Compassion can Free You From Anxiety, Fear and Panic*. New York: Harbinger. Comes with a very useful CD.
- Foreman, E.I., Elliott, C. and Smith, L. (2008). *Overcoming Depression for Dummies*. Chichester: Wiley. This recently published self-help book for depression is full of helpful pointers and tips. Don't be put off by the title!
- Lazarus, R. (1999). *Stress and Emotions: a New Synthesis*. New York: Free Association Press.
- Leahy, R. (2006). *The Worry Cure*. New York: Piatkus Books. Useful if you tend to ruminate and fret about things (don't we all!). There is also a CD that goes with this.
- Lyubomirsky, S. (2007). *The How of Happiness*. New York: Sphere. Useful for finding out how to develop happiness.
- Marra, T. (2003). *The Dialectical Behavior Therapy Workbook for Overcoming Depression and Anxiety*. Oakland, CA: New Harbinger Publications. A helpful guide from a slightly different approach.
- Nesse, R. and Williams, G. (1996). *Evolution and Healing. The New Science of Darwinian Medicine*, London: Phoenix.
- Stewart, A. (1993). *Tired All the Time*. London, Optima. Explores common causes of tiredness, including things like allergy and diet.
- Stone, H. and Stone, S. (1993). *Embracing Your Inner Critic: Turning Self-criticism into a Creative Asset*. New York: HarperCollins. Explores in detail some origins and consequences of self-criticism. Not specific to depression.
- Veal, D. and Willson, R. (2008). *Manage Your Mood*. London: Constable & Robinson.
- Williams, C.J. (2001). *Overcoming Depression: A Five Areas Approach*. London: Arnold.
- Williams, M., Teasdale, J., Segal, Z. and Kabat-Zinn, J. (2007). *The Mindful Way Through Depression: Freeing Yourself From Chronic Unhappiness*. New York: Guilford. This is the first book on mindfulness dedicated to depression and comes with a CD to guide your practice. These authors are well-respected international researchers in depression and mindfulness.
- Other self-help books in the same series as this one are also available: *Overcoming Low Self-Esteem, Stress, Anxiety, Childhood Trauma, Grief, Insomnia, Obsessive Compulsive Disorder, Panic and Agoraphobia, Traumatic Stress, Social Anxiety and Shyness, Worry, Mood Swings* (see www.overcoming.co.uk).

MEDITATION

Two useful book/CD combinations:

- Dagsey Tulku Rinpoche (2002). *The Practice of Tibetan Meditation: Exercises, visualisations, and mantras for health and well being*. Rochester, VT: Inner Traditions. This book offers a very useful set of postures and exercises, along with a CD of mantras and instructions.
- Kornfield, J. (2004). *Meditation for Beginners*. New York: Bantam Books. A good introduction.

MINDFULNESS

The Dalai Lama is the spiritual head of Buddhism, which can be seen as both a spiritual approach and a basic psychology. It's particularly useful for its psychology and insights built up over thousands of years of meditation and introspective observation.

Dalai Lama (1995). *The Power of Compassion*. London: Thorsons.

Dalai Lama (ed. N. Vreeland) (2001). *An Open Heart: Practising Compassion in Everyday Life*. London: Hodder & Stoughton.

Two classics:

Kabat-Zinn, J. (2005). *Coming to Our Senses: Healing ourselves and the world through mindfulness*. New York: Piatkus.

Thich Nhat Hanh (1991). *The Miracle of Mindfulness*. London: Rider.

Other books:

Bikshu Sangharakshita (2008). *Living with Kindness: The Buddha's Teaching on Metta*. London: Windhorse Publications.

Hopkins, J. (2001). *Cultivating Compassion: A Buddhist perspective*. New York: Doubleday.

Ricard, M. (2007) *Happiness: A Guide to Developing Life's Most Important Skill*. New York: Atlantic Books.

If you want a more technical approach, have a look at:

Davidson, R.J. and Harrington, A. (eds) (2002). *Visions of Compassion: Western Scientists and Tibetan Buddhists Examine Human Nature*. New York: Oxford University Press.

Gilbert, P. (2005). *Compassion: Conceptualisations, Research and Use in Psychotherapy*. London: Routledge (pages 148–67).

Leighton, T.D. (2003). *Faces of Compassion: Classic Bodhisattva Archetypes and their Modern Expression*. Boston: Wisdom Publications.

Vessantara (1993). *Meeting the Buddhas: A Guide to Buddha, Bodhisattvas, and Tantric Deities*. London: Wisdom Books.

CDs

Some useful CDs that will guide you:

Brantley, J. (2003). *Calming Your Anxious Mind: How Mindfulness and Compassion Can Free You from Anxiety, Fear and Panic*. New York: Harbinger.

Chodron, P. (2007). *How to Meditate: A Practical Guide To Making Friends With Your Mind*. Boulder, CO: Sounds True.

Kabat-Zinn, J. (2005). *Guided Mindfulness Meditation*. Boulder, CO: Sounds True.

Williams, M., Teasdale, J., Segal, Z., and Kabat-Zinn, J. (2007). *The Mindful Way through Depression: Freeing yourself from chronic unhappiness*. Boulder, CO: Sounds True.

Finding help

Useful websites

FOR DEPRESSION

Beyondblue

www.beyondblue.org.au

This is thought to be one of the best self-help and information depression-focused websites in the world. It is full of helpful ideas and advice.

Living life to the full

www.livinglifetothefull.com

This website has been sponsored by the UK government and is another very helpful and important website for depressed people.

Derbyshire depression website

www.derbysmhnice.co.uk

The Derbyshire Mental Health Services NHS Trust has developed its own website which has general as well as local interest.

NICE Guidelines

www.nice.org.uk/Guidance/CG23

NICE is the British government's guideline body that offers advice on the treatments of various conditions. It brings a range of clinicians together to develop that advice. You can find out the guidelines for depression at the address given here.

FOR COMPASSION-FOCUSED WORK

Compassionate Mind Foundation

www.compassionatemind.co.uk

In 2007, a number of colleagues and I set up a charity called the Compassionate Mind Foundation. On this website, you'll find various essays and details of other sites that look at different aspects of compassion. You'll also find a lot of material that you can use for meditation.

Mind and Life Institute

www.mindandlife.org

The Dalai Lama has formed relationships with Western scientists to develop a more compassionate way of living. More information on this can be found on this website.

Self-Compassion

www.self-compassion.org

The website of Dr Kristin Neff, one of the leading researchers into self-compassion.

Useful organizations

UK

MIND, The National Association for Mental Health

Granta House
15–19 Broadway
Stratford
London E15 4BQ
Tel.: 020 8519 2122
www.mind.org.uk

A very helpful organization that can offer advice on services for a wide range of psychological difficulties. It also has a wide range of literature.

Association for Post Natal Illness

145 Dawes Road
Fulham
London SW6 7EB
Tel: 0207 386 0868
<http://apni.org>

MDF The Bipolar Organisation

Castle Works
21 St. George's Road
London SE1 6ES
Tel.: 08456 340 540 (UK only)
Tel: 0044 207 793 2600 (Rest of world)
www.mdf.org.uk

Depression Alliance

212 Spitfire Studios
63–71 Collier Street
London N1 9BE

www.depressionalliance.org/
Email: information@depressionalliance.org
Tel.: 0845 123 23 20

Seasonal Affective Disorder (SAD) Association

PO Box 989
Steyping
BN44 3HG
www.sada.org.uk

SANE

A general website for mental health problems.
www.sane.org.uk

Samaritans

An outline of the work of the Samaritans and also how to contact them if you want to contact somebody confidentially.

www.samaritans.org
Email: jo@samaritans.org

Befrienders Worldwide

This is a worldwide support website for people who are distressed and suicidal with various contacts.
www.befrienders.org

British Association for Behavioral and Cognitive Psychotherapies

www.babcp.com

NORTH AMERICA

American Psychological Association

www.apa.org
A useful website carrying various articles on mental health issues.

National Alliance on Mental Illness

www.nami.org

Depression and Bipolar Support Alliance (DBSA)

730 N. Franklin Street, Suite 501
Chicago, Illinois 60654-7225
Toll free: (800) 826-3632
www.dbsalliance.org

Association for Behavioral and Cognitive Therapies

305 7th Avenue, 16th Fl.
New York, NY 10001
Phone (212) 647-1890

Behavior Therapy of New York

51 East 42nd Street, Suite 1400
New York, NY 10017
Tel.: (646) 522-7795

Center for Cognitive-Behavioral Psychotherapy

137 East 36th Street
New York
NY 10016
Tel.: (212) 686-6886

The American Institute for Cognitive Therapy

136 East 57th Street, Suite 1101
New York
NY 10022
www.cognitivetherapynyc.com/

HELPLINES FOR SEXUAL ABUSE (UK BASED)

Careline

For all adult survivors of childhood sexual abuse.
0845 122 8622
www.carelineuk.org

Rape and Sexual Abuse Support Centre

Offers support and information for women and girls who have been raped or sexually abused, however long ago.
08451 221 331
<http://rasasc.bizview.co.uk/>

Survivors UK

For survivors of male rape and sexual abuse.
0845 122 1201
www.survivorsuk.org

National Association for People Abused in Childhood

Does not offer counselling or ongoing support but will listen, validate and do whatever is most helpful to the caller.
Support Line 0800 085 3330
www.napac.org.uk

Notes and references

These notes are intended for readers who would like more technical information or ideas to follow up.

Chapter 1: What is depression?

There is now much information on the Internet about depression. Websites such as *beyondblue* (www.beyondblue.org.au) and *Living Life to the Full* (www.livinglifetothefull.com) are excellent sources for further reading.

A good basic book is Power, M. (ed.) (2004). *Mood Disorders: A Handbook of Science and Practice*. Chichester: Wiley. For my own technical work on depression, see Gilbert, P. (2007) *Psychotherapy and Counselling for Depression* (3rd edition). London: Sage.

Chapter 2: Causes of depression: How and why it happens

I go into more detail on these themes in a recent book: Gilbert, P. (2009). *The Compassionate Mind: A New Approach to Life Challenges*. London: Constable & Robinson. I am also just completing a technical book (*Compassion-Focused Therapy: An Introduction to the Theory and Practice*) for Routledge.

- 1 Depue, R.A. and Morrone-Strupinsky, J.V. (2005). A neurobehavioral model of affiliative bonding. *Behavioral and Brain Sciences* 28, 313–395.
- 2 LeDoux, J. (1998). *The Emotional Brain*. London: Weidenfeld & Nicolson.
- 3 For a good, accessible account of the evolutionary approach to depression see Keedwell, P. (2007). *How Sadness Survived: The Evolutionary Basis of Depression*. Oxford: Radcliffe Publishing. I have also discussed this in more detail in Gilbert, P. (2007). *Psychotherapy and Counselling for Depression* (3rd edition). London: Sage.
- 4 Siegle, G., Carter, C.S. and Thase, M.E. (2006). Use of fMRI to predict recovery from unipolar depression with cognitive behavior therapy. *American Journal of Psychiatry*, 163, 735–738.
- 5 Carter, C.S. (1998). Neuroendocrine perspectives on social attachment and love. *Psychoneuroendocrinology*, 23, 779–818. See also Wang, S. (2005). A conceptual framework for integrating research related to the physiology of compassion and the wisdom of Buddhist teachings. In Gilbert, P. (ed.) *Compassion: Conceptualisations, Research and Use in Psychotherapy* (pp. 75–120). London: Brunner-Routledge.

Chapter 3: How evolution may have shaped our minds for depression

- 1 Perhaps one of the most comprehensive books on emotions and their functions is by Oatley, K., Keltner, D. and Jenkins, J. (2006). *Understanding Emotions* (2nd revd edition). Oxford: Blackwell.
- 2 Fredrickson, B.L. (1998). What good are positive emotions? *Review of General Psychology*, 2, 300–319. See also our work: Gilbert, P., McEwan, K., Mitra, R., Franks, L., Richter, A. and Rockliff, H. (2008) Feeling safe and content: A specific affect regulation system? Relationship to depression, anxiety, stress and self-criticism. *Journal of Positive Psychology*, 3, 182–191.
- 3 As noted in the last chapter, a good accessible account of the evolutionary approach to depression is the book by Keedwell (2007). I have also discussed this in more detail in Gilbert, P. (2007) *Psychotherapy and Counselling for Depression* (3rd edition). London: Sage.
- 4 This view was popularized by Nesse, R.M. (2000). Is depression an adaptation? *Archives of General Psychiatry*, 57, 14–20. I have discussed this in Gilbert, P. (2007) *Psychotherapy and Counselling for Depression* (3rd edition). London: Sage.
- 5 My recent book (Gilbert 2009) covers some of these ideas. A very readable book is by Smith, E.O. (2002). *When Culture and Biology Collide: Why we are Stressed, Depressed and Self-Obsessed*.

Chapter 4: Bodies, genes, stress and coping: More on the mind– body link

- 1 A good overview and guide to this work can be found in Caspi, A., Sugden, K., Moffitt, T.E. et al. (2003). Influence of life stress on depression: Moderation by a polymorphism in the 5-HTT gene. *Science* 301, 386–398. For a more general discussion see Caspi, A. and Moffitt, T.E. (2006). Gene-environment interactions in psychiatry: Joining forces with neuroscience. *Nature Reviews: Neuroscience* 7, 583–590.
- 2 Panksepp, J. (1998). *Affective Neuroscience*. New York: Oxford University Press.
- 3 Cozolino, L. (2007). *The Neuroscience of Human Relationships: Attachment and the Developing Brain*. New York: Norton. See also Gerhardt, S. (2004). *Why Love Matters. How Affection Shapes a Baby's Brain*. London: Routledge.
- 4 Lazarus, R.S. (1999). *Stress and Emotions: A New Synthesis*. London: Free Association Press. An accessible book, offering an excellent overview of his work for those who would like to read more on the subject.

Chapter 5: Early life and the psychological and social aspects of depression

- 1 Beck, A.T. (1976). *Cognitive Therapy and the Emotional Disorders*. New York: International Universities Press. Leahy, R. L and Holland, S.J. (2000). *Treatment Plans and Interventions for Depression and Anxiety Disorders*. New York: Guilford Press.
- 2 Perry, B.D., Pollard, R.A., Blakley, T.L., Baker, W.L. and Vigilante, D. (1995). Childhood trauma, the neurobiology of adaptation and 'use-dependent' development of the brain: How 'states' become 'traits'. *Infant Mental Health Journal* 16, 271–291.
- 3 Gerhardt, S. (2004). *Why Love Matters. How Affection Shapes a Baby's Brain*. London: Routledge. Cozolino, L. (2007). *The Neuroscience of Human Relationships: Attachment and the Developing Brain*. New York: Norton.
- 4 Caspi, A. and Moffitt, T.E. (2006). Gene-environment interactions in psychiatry: Joining forces with neuroscience. *Nature Reviews: Neuroscience* 7, 583–590.
- 5 There are many books now on childhood sexual abuse, because sadly it is common in depressed people. The present book does not go into detail on this but you might like to look, for example, at Ainscough, C. and Toon, K. (2000). *Breaking Free Workbook: Practical Help for Survivors of Child Sexual Abuse*. London: Sheldon Press. We also know that various forms of abuse, emotional neglect and hurting can leave people vulnerable (not just sexual abuse). See for example Bifulco, A. and Moran, P. (1998). *Wednesday's Child: Research into Women's Experiences of Neglect and Abuse in Childhood, and Adult Depression*. London: Routledge. For some more recent research see Teicher, M.H., Samson, J.A., Polcari, A. and McGlothery, C.E. (2006). Sticks and stones and hurtful words: Relative effects of various forms of childhood maltreatment. *American Journal of Psychiatry*, 163, 993–1000.
- 6 There is now considerable evidence of these parenting styles and their impact on people. This research has been pioneered by attachment theorists. An excellent review of this work, written by the leading researchers in this area can be found in Mikulincer, M. and Shaver, P.R. (2007). *Attachment in Adulthood: Structure, Dynamics, and Change*. New York: Guilford.
- 7 Brown, G.W. and Harris, T.O. (1978). *The Social Origins of Depression*. London: Tavistock. Brown, G.W., Harris, T.O. and Hepworth, C. (1995). Loss, humiliation and entrapment among women developing depression: A patient and non-patient comparison. *Psychological Medicine* 25, 7–21.
- 8 Champion, L. and Power, M. (1995). Social and cognitive approaches to depression: Towards a new synthesis. *British Journal of Clinical Psychology* 34, 485–503.

Chapter 6: The relationship between our thoughts and feelings in depression

- 1 The idea that automatic thoughts arise from our core beliefs and attitudes and underpin and maintain depression was developed by the psychiatrist Aaron Beck: see Beck, A.T., Rush, A.J., Shaw, B.F. and Emery, G. (1979). *Cognitive Therapy of Depression*. New York: Wiley. The British government's assessment committee (called NICE) that looked into the value of different therapies for depression found that there is good evidence to suggest cognitive behavior therapy helps a number of people with depression, but not all. Beck also understood the importance of understanding how our minds have evolved as being central to understanding depression: see

- Beck, A.T. (1987). Cognitive models of depression. *Journal of Cognitive Psychotherapy: An International Quarterly*, 1, 5–38.
- 2 Haidt, J. (2001). The emotional dog and its rational tail: A social intuitionist approach to moral judgement. *Psychological Review*, 108, 814–834. Baldwin, M.W. and Dandeneau, S.D. (2005). Understanding and modifying the relational schemas underlying insecurity. In Baldwin, M.W. (ed.) *Interpersonal Cognition* (pp.33–61). New York: Guilford. Mark Baldwin is at the forefront of research on how faces affect our feelings and his book on interpersonal cognition is well worth a look. To find out more about his research on games and emotion visit his websites, www.selfesteemgames.mcgill.ca and www.mindhabs.com
- 3 Leahy, R.L. (2002). A model of emotional schemas. *Cognitive and Behavioral Practice*, 9, 177–171.

Chapter 7: Mindful preparations for working with depression

- 1 This account is a modified version of the chapter that appears in my book *The Compassionate Mind: A New Approach to Life Challenges*, mentioned earlier, but here we will be more focused on depression.
- 2 Williams, M., Teasdale, J., Segal, Z. and Kabat-Zinn, J. (2007). *The Mindful Way Through Depression: Freeing Yourself From Chronic Unhappiness*. New York: Guilford. This is the first book on mindfulness dedicated to depression and comes with a CD to guide your practice. These authors are well respected international researchers in depression and mindfulness.
- 3 Keep in mind that if you would like to know more about this and get more into the deep aspects of practice then you would benefit from guided practice by a trained teacher or trainer. However, to get you started there are many good books that outline the basic practice of mindfulness. Some I have found helpful are Gunaratana, B.H. (2002). *Mindfulness in Plain English*. Boston: Wisdom Publications; Kabat-Zinn, J. (2005). *Coming to our Senses: Healing Ourselves and the World Through Mindfulness*. New York: Piatkus; Brantley, J. (2003). *Calming Your Anxious Mind: How Mindfulness and Compassion Can Free You from Anxiety, Fear and Panic*. New York: Harbinger.
- 4 Gilbert, P. (2007). *Overcoming Depression: Talks with your Therapist CD*. London: Constable & Robinson.
- 5 Gilbert, P. and Procter, S. (2006). Compassionate mind training for people with high shame and self-criticism: A pilot study of a group therapy approach. *Clinical Psychology and Psychotherapy* 13, 353–379. If you would like to try some CDs that take you through various mindful exercises then Chodron, P. (2007). *How to Meditate: A Practical Guide to Making Friends with Your Mind* offers an extensive course, or if you want something shorter you might like Bodhipaksa (2005) *Guided Meditations for Busy People*. For videos and websites on mindfulness and compassion, see the Compassionate Mind Foundation website, www.compassionatemind.co.uk.

Chapter 8: Switching our minds to kindness and compassion

- 1 You can read more about self-compassion on Kristen Neff's website at www.self-compassion.org. Neff is a major international researcher in self-compassion. Look at our own Compassionate Mind Foundation website at www.compassionatemind.co.uk.
- 2 Lutz, A., Brefczynski-Lewis, J., Johnstone, T. and Davidson, R.J. (2008). Regulation of the neural circuitry of emotion by compassion meditation: Effects of meditative expertise. *Public Library of Science* 3, 1–5. Rein, G., Atkinson, M. and McCraty, R. (1995). The physiological and psychological effects of compassion and anger. *Journal for the Advancement of Medicine* 8, 87–105. These researchers found that anger images and fantasies had a detrimental effect on the functioning of the immune system, whereas compassion-focused fantasies and images had a very positive effect. You'll also find a review of lots of studies of how mind training affects the body in Begley, S. (2007). *Train Your Mind, Change Your Brain*. New York: Ballantine Books. Another book you may want to look at is Doidge, N. (2007). *The Brain that Changes Itself: Stories of Personal Triumph from the Frontiers of Brain Science*. New York: Penguin.
- 3 The creation of compassionate imagery for the purposes of self-development has a long history. A good but very technical book is Leighton, T.D. (2003). *Faces of Compassion: Classic Bodhisattva Archetypes and their Modern Expression*. Boston: Wisdom Publications. Another good book that covers these imagery exercises is Vessantara (1993). *Meeting the Buddhas: A guide to Buddha, Bodhisattvas, and Tantric Deities*. London: Wisdom Books.
- 4 Frederick, C. and McNeal, S. (1999). *Inner Strengths: Contemporary Psychotherapy and Hypnosis for Ego Strengthening*. Mahwah, NJ: Lawrence Erlbaum Associates. An interesting

study is Wheatley, J., Brewin, C.R., Patel, T. et al. (2007). 'I'll believe it when I see it': Imagery re-scripting of intrusive sensory memories. *Journal of Behavior Therapy and Experimental Psychiatry* 39, 371–385.

- 5 Dandeneau, S.D., Baldwin, M.R., Baccus, J.R., Sakellaropoulos, M.P. and Pruessner J.C. (2007). Cutting stress off at the pass: Reducing vigilance and responsiveness to social threat by manipulating attention. *Journal of Personality and Social Psychology* 93, 651–666.
- 6 Childre, D. and Martin, H. (2000). *The HeartMath Solution*. San Francisco: Harper Collins.

Chapter 9: Changing unhelpful thoughts and feelings: Balance and compassion

- 1 Beck was one of the first to point out that the state of depression influences how we attend, think and reason about things in our lives – depression gives us negative biases. See Beck, A.T., Rush, A.J., Shaw, B.F. and Emery, G. (1979). *Cognitive Therapy of Depression*. New York: Wiley. There are now many self-help books that help people work on these biases. For example Williams, C.J. (2001). *Overcoming Depression: A Five Areas Approach*. London: Arnold. Leahy, R. (2006). *The Worry Cure*. New York: Piatkus Books is useful if you tend to ruminate and fret about things (don't we all!). There is also a CD that goes with this. A helpful guide from a slightly different approach is Marra, T. (2003). *The Dialectical Behavior Therapy Workbook for Overcoming Depression and Anxiety*. Oakland, CA: New Harbinger Publications.
A recently published self-help book for depression is Foreman, E.I., Elliott, C. and Smith, L. (2008). *Overcoming Depression for Dummies*. Chichester: Wiley.
The CD that goes with this book, *Overcoming Depression: Talks with Your Therapist*, contains various talks and exercises.

Chapter 10: Styles of depressive thinking: How to develop helpful styles

- 1 The books listed in the notes for Chapter 9 are also relevant here.
- 2 Gilbert, P. (1998). The evolved basis and adaptive functions of cognitive distortions. *British Journal of Medical Psychology*, 71 447–463 gives a technical and evolutionary approach to how cognitive biases work, while Tobena, A., Marks, I. and Dar, R. (1999). Advantages of bias and prejudice: An exploration of their neurocognitive templates. *Neuroscience and Behavioral Reviews*, 23, 1047–1058 offers a very good, detailed approach to how and why so much of our thinking is biased.

Chapter 11: Writing things down: How to do it and why it can be helpful for us

- 1 Pennebaker, J.W. (1997). *Opening Up: The Healing Power of Expressing Emotions*. New York: Guilford. More technical is Smyth, J.M. and Pennebaker, J.W. (eds) (2008). Boundary conditions of expressive writing. *Health Psychology (Special Section)*. *British Journal of Health Psychology* 13, 1–95.
- 2 Forgiveness research has taken off recently: see Worthington, E.L., O'Connor, L. E., Berry, J.W., Sharp, C., Murray, R. and Yi, E. (2005). Compassion and forgiveness: Implications for psychotherapy. In Gilbert, P. (ed). *Compassion: Conceptualisations, Research and Use in Psychotherapy* (pp. 168–192). London: Routledge. Worthington's website (www.forgiving.org) provides a lot more information on how forgiveness can help us in many ways but is not submissive acceptance.
- 3 Lyubomirsky, S. (2007). *The How of Happiness*. New York: Sphere. A very readable book that makes accessible a lot of the research on gratitude and appreciation and how and why they can help us develop feelings of well-being and counteract depression.

Chapter 12: Changing your behavior: A compassionate approach

- 1 Martell, C.R., Addis, M.E., and Jacobson, N.S. (2001). *Depression in Context: Strategies for Guided Action*. New York: Norton. A technical study on this approach is by Dimidjian, S., Hollon, S.D., Dobson, K.S. et al. (2006). Randomized trial of behavioral activation, cognitive therapy, and antidepressant medication in the acute treatment of adults with major depression. *Journal of Consulting and Clinical Psychology* 74, 658–670.
- 2 Veal, D. and Willson, R. (2008). *Manage Your Mood*. London: Constable & Robinson.
- 3 Ross, J. (2003). *The Mood Cure*. London: Thorsons. Although it is a bit hyped it seems good to me on the issues of diet and supplements – I found it interesting and well written, although the evidence is still developing so I can't vouch for that.

Chapter 13: Stop criticizing and bullying yourself: How to treat yourself with compassion

- 1 Self-criticism has been associated with a lot of mental health difficulties including eating disorders, alcohol problems, anxiety and of course depression. For a technical account of this, see Gilbert, P. and Irons, C. (2005). Focused therapies and compassionate mind training for shame and self attacking. In Gilbert, P. (ed.) *Compassion: Conceptualisations, Research and Use in Psychotherapy* (pp. 263–325). London: Routledge. We also know that self-criticism is not just about negative thoughts but it is people's feelings about themselves that is crucial. See Whelton, W.J. and Greenberg, L.S. (2005). Emotion in self-criticism. *Personality and Individual Differences*, 38, 1583–1595. There are now many self-help books on self-criticism and how to heal it.
- 2 A classic text in this regard is Lasch, C. (1979). *Culture of Narcissism: American Life in an Age of Diminishing Expectations*. New York: Norton. See also McKinley, N.M. (1999). Women and objectified body consciousness: Mothers' and daughters' body experience in cultural, developmental and familial context. *Developmental Psychology* 35, 760–769. There have been many studies showing the negative effect of the media on self-esteem. See for example Mazzeo, S.E., Trace, S.E., Mitchell, K.S. and Walker Gow, R. (2007). Effects of a reality TV cosmetic surgery makeover program on eating disordered attitudes and behaviors. *Eating Behaviors* 8, 390–397. Basically these programmes can lead people to compare themselves unfavourably with others. James, O. (1997) *Britain on the Couch*. London: Arrow Books also goes into this in excellent detail and you can watch the videos of two documentaries on his website (www.selfishcapitalist.com).
- 3 Gilbert, P., Broomhead, C., Irons, C. et al. (2007). Striving to avoid inferiority: Scale development and its relationship to depression, anxiety and stress. *British Journal of Social Psychology* 46, 633–648.
- 4 Work by Cory Gelsma found that feeling less favoured as a child was highly linked to depression. Gilbert, P. and Gelsma, C. (1999). Recall of favouritism in relation to psychopathology. *British Journal of Clinical Psychology* 38, 357–373.
- 5 Bernice Andrews has looked at the relationship between child sexual abuse and chronic depression. See for example Andrews, B. (1998). Shame and childhood abuse. In Gilbert, P. and Andrews, B. (eds) *Shame: Interpersonal Behavior, Psychopathology and Culture* (pp. 176–190). New York: Oxford University Press.
- 6 There are now many reports and self-help books on the theme of childhood sexual abuse. One that gives a number of exercises to work through is Ainscough, C. and Toon, K. (2000). *Breaking Free Workbook: Practical Help for Survivors of Child Sexual Abuse*. London: Sheldon.
- 7 Gilbert, P., Clarke, M., Kempel, S., Miles, J.N.V. and Irons, C. (2004). Criticizing and reassuring oneself: An exploration of forms, style and reasons in female students. *British Journal of Clinical Psychology* 43, 31–50. For a review see Gilbert and Irons (2005), mentioned earlier.

Chapter 14: Depressed ways of experiencing ourselves: How compassionate re-focusing can change our experience

See the notes for Chapter 13.

Chapter 15: Further ways of helping ourselves change

See the notes for Chapters 9–13.

Chapter 16: Approval, subordination and bullying: Key issues in relationships

- 1 This chapter follows a clinical and evolutionary approach to the importance of relationships: see Gilbert, P. (2007). *Psychotherapy and Counselling for Depression*. London: Sage. There is much research now showing how relationships are important in depression. One well-researched approach to depression is McCullough, J.P.Jr (2000). *Treatment for Chronic Depression: Cognitive Behavioral Analysis System of Psychotherapy*. New York: Guilford. This teaches people what to think about and how to act in relationships in order to feel more in control and build helpful relationships. There is a good review of evidence of the importance of relationships to our well-being in Gurman, A.S. and Jacobson, N.S. (eds.) (2002). *Clinical Handbook of Couple*

Therapy (3rd edition). New York: Guilford Press. It is also the case that many of our emotions are evolved to operate in and through social relationships. See for example Tracy, J.L., Robins, R.W. and Tangney, J.P. (eds) (2007). *The Self-Conscious Emotions: Theory and Research* (pp. 283–309). New York: Guilford.

Social neuroscience is a new branch of neuroscience that focuses on the importance of relationships to the way our brain works and our mental health. A good introduction to this is Cacioppo, J.T., Berston, G.G., Sheridan, J.F. and McClintock, M.K. (2000). Multilevel integrative analysis of human behavior: Social neuroscience and the complementing nature of social and biological approaches. *Psychological Bulletin* 126, 829–843. You might also enjoy Cozolino, L. (2007). *The Neuroscience of Human Relationships: Attachment and the Developing Brain*. New York: Norton. You might also want to revisit Chapter 2. This chapter just touches the tip of a large and growing iceberg of knowledge about the importance of how we respond to and think about social relationships.

- 2 A very readable introduction to mind reading for the general reader is O'Connell, S. (1998). *Mindreading: How We Learn to Love and Lie*. New York: Arrow Books. There is also a new therapy approach called mentalizing which helps people to develop their abilities for empathy and to work out why and what others are thinking and feeling. For example, people can be unkind if they are tired or stressed, and it may have nothing to do with oneself. Some people really struggle to consider what might be going on in the minds of other people: see Allen, J.G. and Fonagy, P. (eds.) (2007). *Handbook of Mentalization-Based Treatment*. Chichester: Wiley. If you want to explore the neuroscience and some of the new work on mirror neurons try Decety, J. and Jackson, P.L. (2004). The functional architecture of human empathy. *Behavioral and Cognitive Neuroscience Reviews* 3, 71–100. All these are really important to how we think about the minds of others and cannot be understood only in cognitive terms.
- 3 A key researcher in this area is John Gottman who studied various physiological responses when couples interact as ways of seeing which couples would stay together and which break up. See Gottman, J.M., Driver, J. and Tabares, A. (2002). Building the sound marital house: An empirically derived couple therapy. In Gurman A.S. and Jacobson, N.S. (eds). *Clinical Handbook of Couple Therapy* (3rd edition, pp.373–399). New York: Guilford.
- 4 There is increasing evidence that feeling trapped is a common experience in depression (including feeling trapped by the illness). Gilbert, P. and Gilbert, J. (2003). Entrapment and arrested fight and flight in depression: An exploration using focus groups. *Psychology and Psychotherapy: Theory Research and Practice* 76, 173–188. Feelings of entrapment are now strongly linked to depression as both cause and consequence. See Brown, G.W., Harris, T.O. and Hepworth, C. (1995). Loss, humiliation and entrapment among women developing depression: A patient and non-patient comparison. *Psychological Medicine* 25, 7–21. See also our own research: Gilbert, P., Gilbert, J. and Irons, C. (2004). Life events, entrapments and arrested anger in depression. *Journal of Affective Disorders* 79, 149–160.
- 5 Wearden, A.J., Tarrier, N., Barrowclough, C., Zastowny, T.R. and Rahil, A.A. (2000). A review of expressed emotion research in health care. *Clinical Psychology Review* 5, 633–666.

Chapter 17: Understanding and healing shame in depression

- 1 There has recently been a major research interest in shame. There is a very good overview in Tracy, Robins and Tangney (2007), mentioned earlier. You might also be interested in Gilbert, P. and Andrews, B. (eds) (1998). *Shame: Interpersonal Behavior, Psycho-pathology and Culture*. New York: Oxford University Press and Gilbert, P. and Miles, J. (2002). *Body Shame*. London: Routledge.
- 2 Gilbert, P. (2009). *The Compassionate Mind: A New Approach to Life's Challenges*. London: Constable & Robinson.
- 3 Kaufman, G. (1989). *The Psychology of Shame*. New York: Springer.
- 4 Bernice Andrews has looked at the relationship between child sexual abuse and chronic depression. See for example Andrews, B. (1998). Shame and childhood abuse. In Gilbert, P. and Andrews, B. (eds) *Shame: Interpersonal Behavior, Psychopathology and Culture* (pp. 176–190). New York: Oxford University Press.
- 5 There are now many reports and self-help books on the theme of childhood sexual abuse. One that gives a number of exercises to work through is Ainscough, C. and Toon, K. (2000). *Breaking Free Workbook: Practical Help for Survivors of Child Sexual Abuse*. London: Sheldon.

Chapter 18: Understanding and coping with guilt

- 1 Tangney, J.P. and Dearing, R.L. (2002). *Shame and Guilt*. New York: Guilford Press. This is a very well written and accessible book that brings the reader up to date with a lot of research. See also Baumeister, R.F., Stillwell, A.M. and Heatherton, T.F. (1994). Guilt: an interpersonal approach. *Psychological Bulletin* 115, 243–267. A very interesting approach to guilt can be found in O'Connor, L.E. (2000). Pathogenic beliefs and guilt in human evolution: Implications for psychotherapy. In Gilbert, P. and Bailey, K.G. (eds.) *Genes on the Couch: Explorations in Evolutionary Psychotherapy* (pp. 276–303). Hove: Brunner-Routledge. You may also be interested in Gilbert, P. (1997). The evolution of social attractiveness and its role in shame, humiliation, guilt and therapy. *British Journal of Medical Psychology* 70, 113–147. A review can be found in Gilbert, P. (2003). Evolution, social roles, and differences in shame and guilt. *Social Research*, 70, 1205–1230.
- 2 Hoffman, M.L. (1991). Empathy, social cognition and moral action. In Kurtines, W.M. and Gewirtz, J.L. (eds.) *Handbook of Moral Behavior and Development. Vol 1: Theory* (pp. 275–301) Hillsdale, NJ: Lawrence Erlbaum Associates.
- 3 Gilbert, P. (2007). *Psychotherapy and Counselling for Depression* (3rd edition). London: Sage.
- 4 Gilbert, P. (2009). *The Compassionate Mind: A New Approach to Facing the Challenges of Life*. London: Constable & Robinson.
- 5 O'Connor, L.E. (2000). Pathogenic beliefs and guilt in human evolution: Implications for psychotherapy. In Gilbert, P. and Bailey, K.G. (eds.) *Genes on the Couch: Explorations in Evolutionary Psychotherapy* (pp. 276–303). Hove: Brunner-Routledge.
- 6 Yalom, I.D. (1980). *Existential Psychotherapy*. New York: Basic Books.
- 7 Baumeister, R.F., Stillwell, A.M. and Heatherton, T.F. (1994). Guilt: an interpersonal approach. *Psychological Bulletin*, 115, 243–267.

Chapter 19: Coping with anger

- 1 Gilbert, P., Irons, C., Olsen, K., Gilbert, J. and McEwan, K. (2006). Interpersonal sensitivities: Their link to mood, anger and gender. *Psychology and Psychotherapy: Theory Research and Practice* 79, 37–51. We have also found that if one broods on one's resentment this is linked to depressed mood too: Gilbert, P., Cheung, M., Irons, C., and McEwan, K. (2005). An exploration into depression focused and anger focused rumination in relation to depression in a student population. *Behavioral and Cognitive Psychotherapy* 33, 273–283.
- 2 Some important work has looked at how we express anger to those above and those below us in the pecking order. Fournier, M.A., Moskowitz, D.S. and Zuroff, D.C. (2002). Social rank strategies in hierarchical relationships. *Journal of Personality and Social Psychology* 83, 425–433.
- 3 Our own and other people's research has also shown that depressed people can feel angry but can be frightened of it and try to suppress it. See Gilbert, P., Gilbert, J. and Irons, C. (2004). Life events, entrapments and arrested anger in depression. *Journal of Affective Disorders* 79, 149–160. Dana Jack has also outlined some fascinating and important issues about the fear of anger in her work on silencing the self. See for example Jack, D.C. (1992). *Silencing The Self: Women and Depression*. New York: HarperCollins (Paperback). There are many books on learning to recognize and cope with anger.

Chapter 20: From anger to assertiveness and forgiveness

- 1 You can read more on the work of Arrindell and his colleagues on assertiveness in a number of papers stretching back to the 1980s. Here are a couple to follow up: Arrindell, W.A., Bridges, K.R., van der Ende, J. et al. (2001). Normative studies with the Scale for Interpersonal Behavior (SIB): II. US students. A cross-cultural comparison with Dutch data. *Behavior Research and Therapy* 39, 1461–1479; Arrindell, W. A., van der Ende, J., Sanderman, R., Oosterhof, L., Stewart, R., and Lingsma, M.M. (1999). Normative studies with the Scale for Interpersonal Behavior (SIB): I. Nonpsychiatric social skills trainees. *Personality and Individual Differences* 27, 417–431. See also http://share.eldoc.ub.rug.nl/FILES/root2/2005/Normstwit/Arrindell_2005_Personal_Indiv_Differen.pdf.
- 2 Bono, G. and McCullough M.E. (2006). Positive responses to benefit and harm: Bringing forgiveness and gratitude into cognitive psychotherapy. *Journal of Cognitive Psychotherapy: An International Quarterly*. 20, 147–158. A helpful review chapter is Worthington, E.L., O'Connor, L.E., Berry, J.W., Sharp, C., Murray, R. and Yi, E. (2005). Compassion and forgiveness:

Implications for psychotherapy. In Gilbert, P. (ed). *Compassion: Conceptualisations, Research and Use in Psychotherapy* (pp. 168–192). London: Routledge.

You will also find a lot on the Internet on forgiveness.

Chapter 21: Dealing with frustrations, disappointments and lost ideals

- 1 Many of the books by the Dalai Lama address these issues from a Buddhist point of view. Craib, I. (1994). *Importance of Disappointment*. London: Routledge is an interesting book outlining how and why disappointment and frustrations are actually key to our personal development; we should not see them as just bad things to be dealt with as they can give insight into our values and self. The late Dr Albert Ellis, a famous New York therapist, also wrote much on the issue of how we impose conditions on life with our insistence on 'must' and 'have to' and telling ourselves things are unbearable. He wrote many books. Dr Windy Dryden, a UK-based therapist, is also a prolific writer on this form of therapy and you will find many outlines of their work on the Internet.

Chapter 22: Summing up

- 1 Morgan, A.J. and Jorm, A. (2008). Self-help strategies that are helpful for the subthreshold depression: A Delphi consensus. *Journal of Affective Disorders*. doi 10.1016.
- 2 Begley, S. (2007). *Train Your Mind, Change Your Brain*. New York: Ballantine Books. I discussed some of this information in Chapter 8. Another book you may want to look at is Doidge, N. (2007). *The Brain that Changes Itself; Stories of Personal Triumph from the Frontiers of Brain Science*. New York: Penguin.

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Note: page numbers in *italic* refer to illustrations or examples. The letter 't' after a page number refers to a table. Where more than one page number is listed against a heading, page numbers in **bold** indicate significant treatment of a subject

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OVERCOMING INSOMNIA AND SLEEP PROBLEMS

*A self-help guide using
Cognitive Behavioral Techniques*

Colin A. Espie

ROBINSON
London

To Aud: my wife and my soulmate

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I would like to thank a number of people who have made a major contribution, in various ways, to the work underlying this book. There are far too many to mention by name, but I hope that by summarizing I can adequately reflect my very sincere gratitude.

First of all I am grateful to the many research colleagues I have known and worked with over the years in Canada, the USA, Australia, Europe and, of course, in the UK. The development and evaluation of CBT for insomnia has been, and continues to be, an international effort, and I have been privileged to be part of that work. Then there is my own research team at the University of Glasgow Sleep Research Laboratory; both current members of my group and those that have worked with me across the years. Scores of highly motivated research fellows, research assistants, research nurses, postgraduates and administrative staff have helped to keep the show on the road. More than that – these people have been the lifeblood of my professional life.

My personal assistant Anita McClelland deserves special thanks, not only for her typing of the drafts of this book, but also for putting up with me over the past ten years! Every productive professional has a good administrator in the background, and I would like to thank Anita for always being there to help.

None of this, of course, would have been possible without our patients and research participants, from whom we find out, through one research method or another, everything that we know about the perplexing yet intriguing disorder that we call ‘insomnia’.

Finally, I have a wonderful and supportive family of whom I am immensely proud: Craig, who is fulfilling his father’s alternative dream by studying and playing music; Carolyn, who is following in our footsteps through her studies in psychology; and our youngest, Robbie, who at five years of age is already able to take charge of most of life’s major decisions! Most of all, there is my alluring and very special wife, Audrey, to whom I dedicate this book with all my love.

Preface

I am writing this preface while on sabbatical leave at Université Laval, Québec City. I had promised myself that the book would be finished around four weeks ago, but I guess to be only a month behind schedule for an undertaking of this size is not so bad. Anyway, that's life, is it not?

The priorities and pressures are such that most of us in academic life spend the majority of our time conducting research, analyzing data, writing scientific papers, and teaching our students. Those of us who are clinical academics also try to fit in seeing the occasional patient or two. In this context, writing books for the general public is at best regarded as a hobby; at worst even a misuse of our time. Yet what is the purpose of knowledge if it is not to share it, and to try to improve things for people?

I struggled with this dilemma for a while. However, I decided last year, after being approached by the publishers, that the time had finally come to 'do the book!' I am sure that other authors in the excellent CBT series that Constable and Robinson produce have probably felt the same way. I guess most of us have a lay readership book in us. Well for better or for worse this one is mine.

It has actually felt very good writing the book. It has given me the opportunity to make available to you the treatment materials that we have developed and evaluated in our research studies. That feels like the right thing to do. What you are getting here is pretty much a complete CBT treatment guide for insomnia; the way I would present it to you if you came to my clinic in Glasgow. Of course, I can't get the particular 'angles' that are special to you and to your sleep problems. However, that said, I am confident that you have a very powerful tool in your hands that will help you towards overcoming your insomnia.

I wish you success as you set out on this course of CBT treatment. Sleep soundly and sleep well.

*Colin A. Espie
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Introduction

by Peter Cooper

Why a cognitive behavioral approach?

You may have picked up this book uncertain as to why a psychological approach, such as a cognitive behavioral one, might help you overcome your sleep problems. A brief account of the history of this form of treatment might be helpful and encouraging. In the 1950s and 1960s a set of therapeutic techniques was developed, collectively termed 'behavior therapy'. These techniques shared two basic features. First, they aimed to remove symptoms (such as anxiety) by dealing with those symptoms themselves, rather than their deep-seated, underlying historical causes (traditionally the focus of psychoanalysis, the approach developed by Sigmund Freud and his associates). Second, they were loosely related to what laboratory psychologists were discovering about the mechanisms of learning, and could potentially be put to the test, or had already been proven to be of practical value to sufferers. The area where these techniques proved to be of most value was in the treatment of anxiety disorders, especially specific phobias (such as extreme fear of animals or heights), notoriously difficult to treat using conventional psychotherapies.

After an initial flush of enthusiasm, discontent with behavior therapy grew. There were a number of reasons for this, an important one was the fact that behavior therapy did not deal with the internal thoughts which were so obviously central to the distress that many patients were experiencing. In particular, behavior therapy proved inadequate when it came to the treatment of depression. In the late 1960s and early 1970s a treatment for depression was developed called 'cognitive therapy'. The pioneer in this enterprise was an American psychiatrist, Professor Aaron T. Beck. He developed a theory of depression which emphasized the importance of people's depressed styles of thinking, and, on the basis of this theory, he specified a new form of therapy. It would not be an exaggeration to say that Beck's work has changed the nature of psychotherapy, not just for depression but for a range of psychological problems.

The techniques introduced by Beck have been merged with the techniques developed earlier by the behavior therapists to produce a therapeutic approach which has come to be known as 'cognitive behavioral therapy' (CBT). This therapy has been subjected to the strictest scientific testing and it has been found to be a highly successful treatment for a significant proportion of cases of depression. It has now become clear that specific patterns of disturbed thinking are associated with a wide range of psychological problems, not just depression, and that the treatments which

deal with these are highly effective. So, effective cognitive behavioral treatments have been developed for anxiety disorders, like panic disorder, generalized anxiety disorder, specific phobias and social phobia, obsessive compulsive disorders, and hypochondriasis (health anxiety), as well as for other conditions such as compulsive gambling, drug addiction, and eating disorders like bulimia nervosa. Indeed, cognitive behavioral techniques have been found to have a wide application beyond the narrow categories of psychological disorders. They have been applied effectively, for example, to helping people with low self-esteem, those with marital difficulties or weight problems, those who wish to give up smoking or excessive drinking, and, as in this book, those with sleep problems.

The starting-point for CBT is the realization that the ways we think, feel and behave are all intimately linked, and changing the way we think about ourselves, our experiences, and the world around us changes the way we feel and what we are able to do. So, for example, by helping a depressed person identify and challenge their automatic depressive thoughts, a route out of the cycle of depressive thoughts and feelings can be found. Similarly, habitual behavioral responses are driven by a complex set of thoughts and feelings, and CBT, as you will discover from this book, by providing a means for the behavior to be brought under cognitive control, enables these responses to be undermined and a different kind of life to be possible.

Although effective CBT treatments have been developed for a wide range of disorders and problems, these treatments are not widely available; and, when people try to help themselves on their own, they often do things which make matters worse. In recent years the community of cognitive behavioral therapists has responded to this situation. What they have done is to take the principles and techniques of specific cognitive behavioral therapies for particular problems and present them in manuals, which people can read and apply themselves. These manuals specify a systematic program of treatment which the individual works through to overcome their difficulties. In this way, cognitive behavioral therapeutic techniques of proven value are being made available on the widest possible basis.

Self-help manuals are never going to replace therapists. Many people will need individual treatment from a qualified therapist. It is also the case that, despite the widespread success of CBT, some people will not respond to it and will need one of the other treatments available. Nevertheless, although research on the use of these self-help manuals is at an early stage, the work done to date indicates that for a great many people such a manual will prove sufficient for them to overcome their problems without professional help. Many people suffer silently and secretly for years. Sometimes appropriate help is not forthcoming, despite their efforts to find it. Sometimes they feel too ashamed or guilty to reveal their problems to anyone. For many of these people the cognitive behavioral self-help manual will provide a lifeline to recovery and a better future.

*Professor Peter Cooper
The University of Reading, 2005*

Introduction

To be unable to sleep is one of life's worst experiences. Insomnia not only affects your night-time, through disrupted and unsatisfactory sleep, but it also has consequences in terms of your quality of life. People with persistent sleep problems of this type often complain of being slowed down mentally or moody during the day. What is more, they are not the only ones who suffer. Broken sleep can affect partners, children, and our social life and working life.

Insomnia is a major public health problem. Billions of dollars are spent worldwide every year on prescribed medications, over-the-counter remedies, and other suggested solutions – all in the search of a decent sleep. One in ten adults, and one in five of those over 65 years of age, have insomnia. Being unable to sleep is one of the most common complaints heard by doctors, yet our healthcare systems are barely scratching the surface in offering a service that will help people.

Research conducted over the past 25 years has established cognitive behavioral therapy (CBT) as an effective treatment for persistent insomnia. Indeed, leading authorities now regard CBT as the treatment of first choice. But there is a problem – CBT is not widely available because clinical psychology services and behavioral medicine services do not have the capacity at this time to meet the potential demand. These are professions that are, in relative terms, still in their infancy. So, while the research has been conducted and the evidence is there, the means to deliver CBT is lagging behind.

As one of the people who has been most closely involved with the development and evaluation of insomnia treatment, I want to help you make the best possible use of the CBT program that we have developed in Scotland. I believe that one of the ways to help overcome the scale of the insomnia problem that is out there is to put the solution, the CBT itself, directly into your hands. We as professionals must, and will, continue to lobby politicians and healthcare providers to develop much-needed services. However, there is also a lot that you can do to improve your sleep yourself, if you are given the right tools for the job.

This book is designed for your use as a CBT treatment manual. I have set out the different parts of the book, and the chapters within each part, so that you can use it as a CBT self-help program. You are about to set out on a course of therapy. I will be your therapist, as it were from a distance, but you must take on the role not only of patient but also of co-therapist. You will be learning and implementing at the same time . . . you will be evaluating your own progress . . . you will get what you give! Like any course of treatment, I ask you to take this CBT program seriously. Give it some of your best-quality time and attention.

In our studies evaluating the effectiveness of CBT we have seen a great many patients who thought they would never be able to sleep well, go on to make huge improvements in the pattern and the quality of their sleep. CBT offers you this prospect. Join me in helping you benefit . . . let's overcome insomnia together!

PART ONE

Understanding Insomnia

Introduction to Part One

The first part of the book is about developing an understanding of sleep and of insomnia. I hope you will find that this is a helpful step towards your goal of learning how to overcome insomnia and how to become a good sleeper. Try not to be tempted to jump ahead to Part Two, especially if you are the kind of person who likes to 'get on with it'! Part One will give you important background information that will make it much easier to put your cognitive behavioral treatment into practice.

Normal Sleep

What Is Sleep?

You may be surprised by this, but I would like to begin by explaining what sleep is *not*. This is important, because sleep is very commonly misunderstood.

First, sleep is *not* simply the absence of wakefulness. Falling asleep is not like having a light switched off, just as wakefulness is not the same as a light switched on. The on/off idea would suggest that we live our lives either at one extreme or the other. This is not in fact correct, because there are variations within sleep, just as there are variations in wakefulness. You are not always ‘wide awake’ . . . are you? Similarly, you are not always ‘fast asleep’.

Second, sleep is *not* an inactive process. Sleep is not ‘down tools’ time, or a kind of respite or escape. On the contrary, the body’s activities during sleep are absolutely vital to life. Your sleep is a part of your life, not something separate from it – you have heard it said that we spend one-third of our lives asleep (I hear you say ‘I wish!’). Just because we are unconscious, and have no memory for the greater part of our sleep, does not mean that sleep is either a simple or a passive state.

So what then *is* sleep? The famous Israeli scientist Dr Peretz Lavie once wrote a semi-autobiographical book about his experiences in sleep research. He called the book *The Enchanted World of Sleep*. For me this title captures the fact that sleep is rich, diverse, and precious; and still fascinatingly mysterious. We live our lives not just in the waking world. Let’s go and take a glimpse at life within sleep.

Research studies have shown us that sleep is a very complex, yet very ordered process. Scientists have discovered the complexity of sleep by studying the activity of the brain during sleep-laboratory recordings. Sleep is made up of different subtypes and stages. Sleep is also orderly, because these types and stages of sleep are organized in a series of cycles that repeat across the night.

Sleep is also active in other ways. For example, it is during sleep that our body tissue is repaired. Proteins, the building-blocks of life, are laid down during sleep, and some hormones are produced selectively during the night, such as the growth hormone in developing infants and children. So there is some truth in the idea that we grow during the night! These are just a few examples of physical processes that occur during sleep, but there are also very important mental processes. We catch a glimpse of this in the phenomenon of dreaming. Of course, we do not always remember our dreams, but when we do what is very apparent is that we have been thinking, even while we were asleep. Enchanting!

Measuring Sleep in the Laboratory

In order to understand this complex process it may be helpful to find out a little about how sleep is ‘measured’ and analyzed; this is usually done in a *sleep laboratory*.

Scientists study sleep by taking three types of measurement.

1. Electrical activity in the brain is measured by *electroencephalography* (EEG). This measure is used because the EEG signals associated with being awake are different from those found during sleep. Also, the different stages of sleep can be measured using EEG.
2. Muscle activity is measured using *electromyography* (EMG), because muscle tone also differs between wakefulness and sleep. Once again, there are EMG differences within sleep, depending upon the stage of sleep.



Figure 1 A typical sleep laboratory assessment taking place

3. Third, eye movements during sleep are measured using *electro-oculography* (EOG). This is a very specific measurement that helps to identify dreaming sleep. The eyeballs make characteristic movements that show us when someone is in this type of sleep.

Figure 1 shows a typical sleep assessment taking place. Electrodes are placed at various points on the scalp and skin to pick up electrical activity. It may sound a bit uncomfortable, but it does not stop most participants from sleeping and it helps experts learn a great deal about sleep. So what happens when we look at normal sleep in a laboratory using EEG, EMG, and EOG?

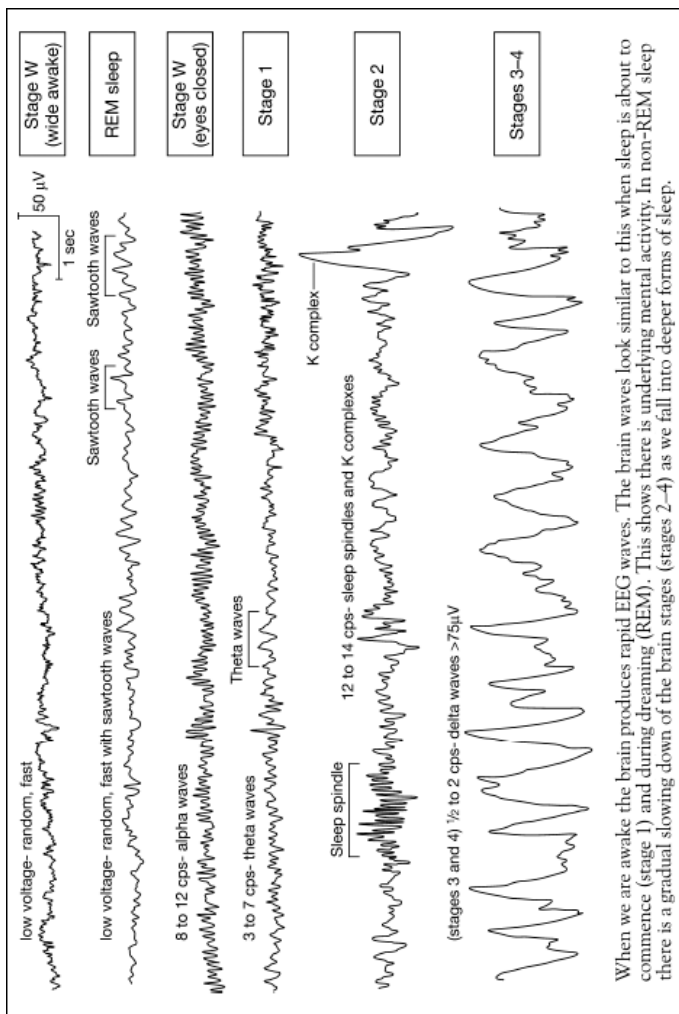


Figure 2 A polysomnographic (PSG) recording showing the different stages of sleep

This whole system of assessment is usually called *polysomnography* (PSG). The prefix ‘poly’ simply refers to the fact that more than one type of physiological activity is being measured. You can see some EEG readings of typical adult sleep in Figure 2. These illustrate the similarities and differences between the different stages of sleep. You can also make some comparisons of sleep with waking.

The Stages of Sleep

Let’s start with waking. Sometimes we call this *Stage W* (wakefulness). You will see that the EEG part of the tracing is characterized by what we call ‘fast activity’. EEG waves are fairly random and of low voltage. You will see in Figure 2 that they are of relatively low height (*amplitude*) and are generated in close proximity to one another

(*high frequency*). Waking EEG of this type is known as *beta* activity. Notice next the difference between this EEG and the one depicted in the third row in Figure 2. This is an EEG of someone in bed with their eyes closed, and you can see that the EEG waves no longer come quite as thick or fast. This is what is called *alpha* activity or *alpha* rhythm.

As we fall asleep we go into a transitional phase between wakefulness and sleep known as *Stage 1* sleep. Compared with quiet wakefulness, the EEG waves in Stage 1 slow down to around three to seven cycles per second (cps). These are known as *theta* waves.

Figure 2 shows only the EEG for Stage 1 sleep, but if you were to see a measurement for muscle tone (EMG) during Stage 1, you would notice that the muscles begin to relax in comparison with wakefulness. Similarly, the EOG traces would change and begin to show slow *rolling eye movements*. Stage 1 sleep normally lasts only a matter of minutes before progressing to Stage 2.

You can see that the EEG varies considerably during *Stage 2* sleep. There are *mixed frequencies* of EEG waves (some fast, some slow, some high amplitude, some low). However, there are two characteristic formations that occur repeatedly, and these are the defining features of Stage 2 sleep. The *K-complex* takes its name from the shape of an initially descending and then ascending sharp change in voltage. By tradition lines on the upward inclination in EEGs are called ‘descending’ and those heading downward are called ‘ascending’ – this may seem odd, but it is the standard terminology. The other features of Stage 2 sleep are known as *sleep spindles* – the name for rapid bursts of high-frequency EEG activity (12–14 cps) that occur intermittently. Although Stage 2 sleep comprises the largest proportion of adult sleep (50–60 per cent), the first phase of Stage 2 sleep is usually quite short.

We have the deepest part of our sleep during the first third of the night, and there is a more rapid transition into *deep sleep* during this period. EEG *Stage 3* and *Stage 4* together make up this deep sleep, sometimes called *slow-wave sleep* because the EEG now reveals higher waves occurring at much lower frequencies. The height of these *delta waves* will be 75 microvolts (μV) or greater, and the wave frequency has now dropped to its lowest at $\frac{1}{2}$ –2 cps. The difference between Stages 3 and 4 is simply the proportion of each 30-second period of sleep analysis during which delta waves are present. For Stage 3 sleep, 20–50 per cent comprises delta waves, whereas more than 50 per cent is required for describing sleep as Stage 4. Deep sleep is a form of *synchronized sleep* because the brain’s electrical activity settles to a harmonized rhythm, and so produces the steady ‘beats’ that you can see in Figure 2.

So far, then, we can see that the transition from wakefulness through to deep sleep involves not only a loss of consciousness, but also a steady change in the EEG wave pattern from fast to slow activity, and that four stages of sleep can be differentiated. However, in 1953 two researchers in Chicago, Dr Kleitman and his young assistant Dr Aserinsky, made a crucial discovery about sleep. They noticed that there was another form of sleep during which the eyeballs move rapidly, whereas the rest of the body is pretty much paralyzed. The term *rapid eye movement (REM) sleep* was coined, and so important was its discovery that all the other Stages (1, 2, 3, and 4) actually became known as non-REM sleep.

You can see in Figure 2 that the EEG during REM sleep does not look very different from wakefulness or from Stage 1 sleep. Indeed, it is a form of light sleep. However, the EOG shows very characteristic eye movements, and the EMG shows a

marked flattening (loss of muscle tone). This actually makes sense when you think that it is during REM sleep that we do most of our dreaming. Were it not for the fact that our major voluntary muscles are relaxed, we could easily injure ourselves by acting out our dreams! You may not have realized before that you are in fact very still in your bed during your dreams, in spite of whatever vivid dream imagery you may experience. Occasional muscle twitches are quite usual, but any movement on a large scale during REM sleep is uncommon. In fact, if this does occur it may mean that the person has a problem known as *REM sleep behavior disorder*. This is not the same as *sleepwalking*, which occurs during periods of non-REM deep sleep. I will explain more about the different disorders of sleep later in this book.

Evaluating a Sleep Recording

Sleep records from the sleep laboratory are *scored* by highly trained professionals into the different stages of sleep. Sometimes we call this process *staging sleep*. We still use a standard set of scoring rules developed in the USA in the late 1960s by Dr Rechtschaffen and Dr Kales. In the early days, information from each recording channel (EEG, EMG, EOG) was printed out and reviewed page by page. Nowadays this information is analyzed on a PC screen and the person doing the scoring scrolls through, allocating each 30-second chunk, or *epoch*, to one of the sleep stages.

After a sleep recording has been scored, the computer generates a *sleep report*. This summarizes the night and provides useful information for the researcher to work with. An example of an abbreviated sleep report from my own lab can be seen in Figure 3. Let me take you through the information presented there.

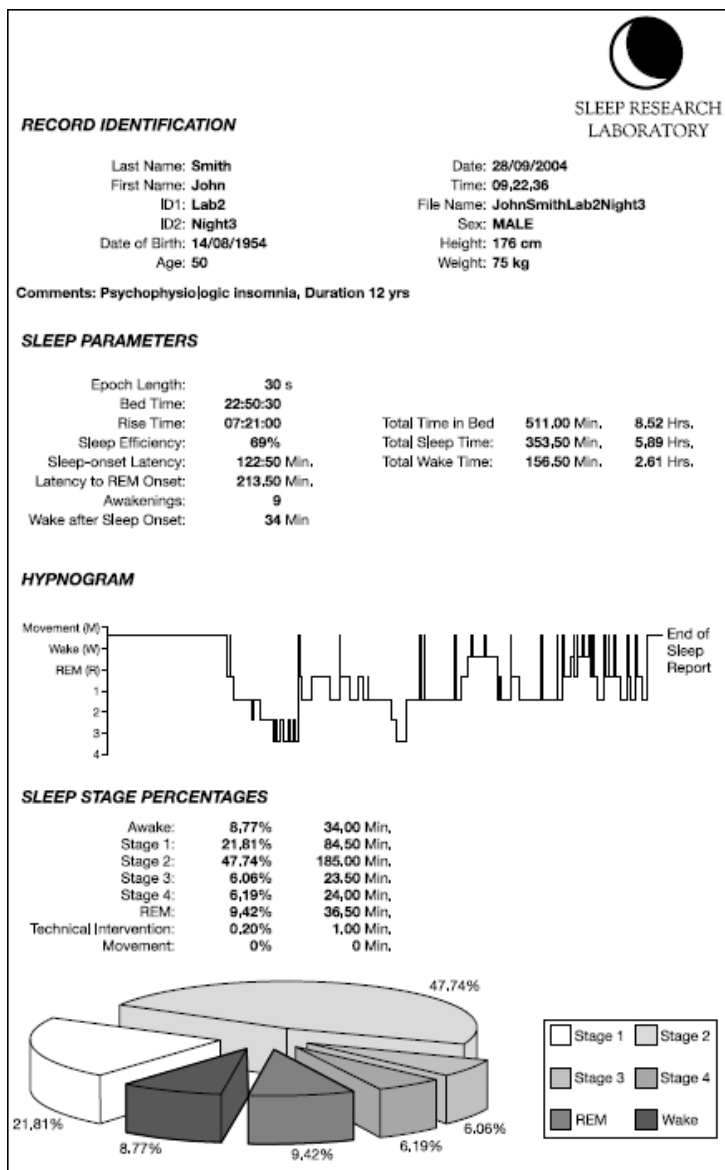


Figure 3 A sample sleep report

You can see that the report begins with *record identification* information about the patient. Obviously we do not want to give away any confidential details, so we have called this 50-year-old man John Smith, and given him a made-up date of birth. He has a diagnosis of 'psychophysiologic insomnia' and has had persistent sleep problems for the past 12 years. You are going to hear a lot more about this type of

insomnia later in this book. Each patient is given a unique sleep study code, and his or her hospital number or research protocol number would usually be included. Here you will see the file name is simply made up from this sample patient's name, the lab bedroom he slept in (lab 2), and the night of his stay (night 3).

Next there is a section of the report headed *sleep parameters*. You can see that we use the standard 30-second epoch length for scoring sleep stages. John Smith's bedtime was recorded as 10:50 p.m. and his rising time as 7:21 a.m. This means that his time in bed (TIB) was just over 8½ hours, at 511 minutes. However, he did not sleep for 8½ hours! As you can see, John Smith has a severe insomnia problem.

We use the term *sleep-onset latency (SOL)* for the length of time it takes someone to fall asleep. Here the SOL is 122 minutes, so it took John Smith more than 2 hours to get to sleep on this particular night. As well as the time taken to get off to sleep, we are interested in whether or not there were problems staying asleep. This report contains two pieces of information about the continuity of John Smith's sleep. You can see that nine *awakenings* from sleep were recorded. *Wake time after sleep-onset (WASO)* is the total amount of time spent awake during these awakenings. Here the WASO was 34 minutes, so we can work out that John Smith's wakeful episodes were relatively brief. Nevertheless, these can be quite disruptive because they impair sleep quality. If you think about it, together SOL and WASO represent the most common insomnia complaints: difficulty getting to sleep, and difficulty staying asleep. John Smith's *total wake time (TWT)* was 156 minutes.

Of course, we also want to know how much sleep John Smith obtained. You can see, therefore, that his *total sleep time (TST)* amounted to 5 hours and 53 minutes.

The sleep parameters section also includes information on something called *sleep efficiency (SE)*. This is an important figure because it tells us the proportion (percentage) of the time in bed that was spent asleep. It is calculated as $TST/TIB \times 100$. In this example, total sleep time (TST) was 353 minutes out of the 511 minutes of time in bed (TIB), so the SE was 69 per cent; a pretty poor night by any standards! Generally, we think of an SE below 85 per cent as being a potential problem, and above 85 per cent as being good sleep. This of course raises the interesting point that it is not necessarily *how much sleep* we get that is important, but *how good a quality* it is. Sleeping through for 6 continuous hours from lights out to waking would give an SE of 100 per cent, whereas getting a total of 6 hours broken up over an 8-hour period would give an SE of only 75 per cent. You will find out later that improving your sleep efficiency is one of the key requirements in overcoming insomnia.

We now move on to the *hypnogram* and the sleep stage percentages. The hypnogram gives us a picture of John Smith's sleep pattern across the night, throughout the different stages of sleep. You can see, for example, that his awakenings generally happened in the second half of the night. The sleep report gives us the *percentage* of the night spent in each stage of sleep (1, 2, 3, 4, REM). Over half the night was spent in Stage 2 sleep, with a further 24 per cent in Stage 1. As I explained earlier, Stage 1 sleep is a transitional form of sleep that normally makes up a relatively small percentage of our total time asleep.

John Smith's total slow-wave or deep sleep can be calculated by adding together his sleep Stages 3 and 4. This amounts to only 47 minutes, or around 13 per cent of the night. So we can deduce that John Smith must be quite a light sleeper.

Looking back to the sleep parameters, you can also see that his *latency to REM onset* – that is, how long it was before the first episode of REM sleep occurred – was

213 minutes on this particular night. This is much longer than we normally find on a good night's sleep, when 60–70 minutes would be more usual. John Smith spent a total of 36 minutes in REM, about half what we would expect to see in a man of his age. Finally, you can see that the report contains sleep stage information on Stage W, and another category, *movement time (M)*, which we use if it is not possible to decide on a sleep or wake stage. This might be when the EEG channels are impossible to read. In John Smith's case this measurement wasn't necessary, though there was a brief *technical intervention* (perhaps checking an electrode) by one of our staff.

Before leaving this topic I want to take a moment to consider whether or not people sleep normally in a sleep laboratory. You might be thinking that with all this equipment attached, your sleep continuity and sleep quality might be quite different . . . and of course there's the added element of being in a strange environment. Dr Jack Edinger from the VA Medical Center, Durham and Duke University, North Carolina, has completed a number of important studies investigating home versus lab-based sleep-assessment (polysomnography, or PSG) in insomnia. His findings are interesting because they suggest that it might be better if sleep could be measured at home, because in a lab setting people can actually sleep *better* than usual. In part this could be due simply to the change of environment. Another possibility is that they might not *expect* to be able to sleep in a lab, and those lower expectations could mean that they are less anxious about sleep, and so sleep better. This research work, then, also introduces us to one of the psychological components of insomnia – the importance of expectations!

On the Experience of Sleep

You have probably never been to a sleep laboratory, but I am sure you have tried to measure your sleep somehow – perhaps by working out how long you think you have slept, or how long it took you to fall asleep, or how many times you woke up during the night. These are measures of the *experience of sleep*, of what you remember about your sleep, and of the conclusions that you draw about your sleep. I bet you have found that it is not easy to calculate these things very accurately.

You may even have tried to keep some type of *Sleep Diary* so that you can see what your sleep is like over a period of time, or to try to work out if there is a pattern. Diaries like this are very useful, and we will be using them quite a bit as we assess and treat your insomnia. What I am saying is that your experience of sleep is *very important*, because that is what you have been living with.

Sometimes it is easier to think about the quality of our sleep rather than its quantity. *Sleep quality* and sleep efficiency have something in common. For example, you might feel that you have had a 'good sleep' or a 'deep sleep' – or, perhaps more likely because you are reading this book, that you have had many nights of 'restless sleep' or 'hardly any sleep', or that it takes you a long time to get into a proper sleep. It's not always easy to convert these kinds of experience into numbers. Whether we are trying to estimate quantity or commenting on sleep quality, this is called *subjective assessment*. But we should not fall into the trap of thinking that subjective assessment is less important than the objective kind (as is done in sleep clinics). What you think and feel about your sleep is extremely important, not least because it is your experience of sleep (or lack of sleep) that usually makes you seek help in the first place.

It is likely that it was your experience of poor sleep that led you to be interested in this book in the first place. So it will be important for you to keep accurate records of your subjective sleep experiences, and I will help you make best use of a Sleep Diary. This form of assessment is recognized internationally as *essential* for clinical work in insomnia. In other words, the experience of insomnia, systematically summarized on a night-to-night basis, is the most important thing in eventually treating it.

There are different sub-types of insomnia, and we will be learning more about these in Chapter 3. One of the more common ones is *psychophysiologic insomnia*. In this form of insomnia, the person's experience of sleep can be confirmed by objective measurements such as PSG. In other words, someone with psychophysiologic insomnia may estimate that on a given night it took 45 minutes to get to sleep, and assessment will confirm that they had difficulty getting off to sleep. Similarly, if the problem was staying asleep (a sleep maintenance problem), both objective tests and self-reports will tend to agree.

However, you may be already familiar with the common finding from research that people usually sleep longer than they think they have done. Research literature tells us that people with insomnia tend to overestimate how long it takes them to fall asleep (SOL), how long they are awake during the night (WASO), and their total amount of sleep (TST). This has been taken by some to mean that people with insomnia 'exaggerate' their problem. Little wonder that many people with insomnia feel that their complaints are not taken seriously. However, this *discrepancy* should not surprise us. People who are normally good sleepers are likely to make very similar 'errors' in estimation on those occasional nights when they sleep poorly. This suggests to me that it is not so much the person with insomnia who is in some way at fault, rather that the task is actually quite a hard one, and one that good sleepers seldom have to perform. During the night, in the absence of stimulation and activity, time can appear to pass rather slowly (don't you know it!).

Another possibility has some support from recent research on insomnia carried out by Dr Michael Perlis at the University of Rochester in New York State. This work suggests that sleep assessment (PSG), when scored in the conventional way into sleep stages, may fail to identify more subtle EEG characteristics that form part of the underlying pattern in insomnia. For example, a tendency towards waking up very, very briefly, or the presence of fast EEG waves (as in wakefulness or light sleep) intruding into sleep, may correspond better to subjective experiences of insomnia. In other words, we may in time need to study sleep using a different set of criteria. Much more research in this area is required.

But I Never Slept a Wink!

'Oh yes, you did,' you will have heard; 'Oh no, I didn't' you may have answered, or felt like answering! Hopefully, the sections above can help you understand how differences can arise in the way people perceive sleep. There is, however, a particular form of insomnia where the hallmark feature is this debate, or I might even say dispute, about whether or not sleep actually occurred.

Clinicians and researchers have come to recognize a disorder that used to be called, until very recently, *sleep state mis-perception*. In this type of insomnia the individual remains convinced that he or she obtained no or hardly any sleep, often

over many years. On the one hand this seems unlikely, but on the other hand there can be no doubt that these beliefs are sincerely held, by perfectly sensible and reasonable people.

When this disorder has been studied in the laboratory, sleep patterns that are fairly normal are often found. How can this be? Well, perhaps these are extreme cases of the disparity between different methods of assessment; the 'subjective-objective discrepancy'. But we might just as accurately conclude that assessments such as PSG are simply not up to capturing the nature of this type of sleep experience. For these reasons, this disorder has now been given the name *paradoxical insomnia*, to reinforce the paradoxical nature of the problem: apparently sleeping well yet complaining of severe insomnia. Paradoxical insomnia should be a priority for further research, and I feel strongly that this diagnosis should not be misused to criticize people who have such symptoms.

Let us never forget, then, that a person's individual experience of sleep may be different from the sleep records obtained in a sleep lab. Both are important, and they are not necessarily in competition with one another for 'right' and 'wrong'. We need to recognize that concern about insomnia is what brings people to the attention of health services. Without that, no help will be offered, or needed. I am sure that time, and good science, will tell that there are better laboratory measures yet to come.

What Controls Our Sleep Pattern?

Two processes are commonly recognized as working together to regulate our sleep pattern. One is called the *sleep homeostat*, and this controls our 'drive' for sleep; the other is called the *circadian timer*, and controls *when* we sleep.

Broadly speaking, the longer we are awake, the sleepier we will become. Extended wakefulness, therefore, increases the body's drive for sleep. In physiology, this kind of process is there to restore balance, so sleep reduces the drive for sleep, and wakefulness increases the sleep drive, in much in the same way that we become parched if we go without fluids, and drinking satisfies that thirst and so reduces the drive to drink.

The famous sleep researcher Dr William C. Dement from Stanford University, California, uses the helpful analogy of the 'sleep economy'. With each hour that we spend awake we accumulate an increasing *sleep debt*. In healthy good sleepers this debt is repaid in full by the night's sleep and they awaken refreshed and back 'in balance' the next morning. The analogy raises the possibility that there are individuals who, perhaps through lifestyle choices or for other reasons, find themselves in a state of chronic sleep debt. Indeed, there may be attitudes within some parts of modern society that encourage such lifestyles and pay scant attention to nature's way of replenishing and restoring the body. The drive for sleep is, naturally, stronger when we first go to bed than it is later on, and this accounts, for example, for why it is that a nap can make us feel much better. Similarly, some people report waking after a couple of hours of sleep and feeling quite awake and refreshed. It is also a reason, of course, to *avoid* napping if you have insomnia, because naps have the potential to reduce the body's drive for sleep during the night, when you really want it to work for you.

You may have heard of the *circadian rhythm*. This is a term used to describe the harmony of the sleep-wake schedule. Other functions apart from sleep, such as body

temperature, also follow recognized circadian patterns. We are designed to function in a 24-hour world. The word ‘circadian’ derives from the Latin words *circa diem*, literally meaning ‘around the day’. Sometimes we talk about the *body clock*, meaning pretty much the same thing.

Our circadian rhythm takes a little while to become established. During early development an infant’s sleep is not organized into day and night phases. Instead, babies sleep and wake across the 24 hours. By around 6 months, however, the major sleep period becomes concentrated and more settled during the night-time hours of darkness, there is more wakefulness during daytime/daylight hours, and the body clock gradually approximates to local time. The hormone *melatonin* is largely responsible for the ongoing regulation of the body clock throughout our lives. Melatonin is produced in the brain, in the *pineal gland*. Its production rate is dictated by natural light, so that during hours of darkness (the normal sleep period) melatonin production increases, and as morning approaches and with the coming of daylight, melatonin production is once again shut down. Of course there is some natural variation in circadian alertness during the daytime. For example, you will probably be aware of the *afternoon dip* when we tend to feel temporarily rather more tired. Indeed, in some societies it is normal to have a siesta at this time because it also coincides with the hottest part of the day. In terms of our circadian tendencies there is much to be said for that lifestyle!

Before moving on from this section, however, it is important to note that it is the *interaction* of the sleep homeostat and the circadian timing mechanism that, under normal circumstances, leads to good sleep. This is when the drive for sleep becomes strongest during normal hours of darkness, and results in an absence of pressure for sleep during wakeful, daylight hours.

I believe there is another component that regulates sleep. I call this *automaticity*. People who sleep well usually have absolutely no idea how they do it. Perhaps you have asked them! My point is that the *automatic* nature of this type of ‘control’ over sleep is crucial to normal, good sleep. Contrast this with insomnia, where the would-be sleeper is often preoccupied by his or her sleep problem and its consequences. I call this the *attention–intention–effort* cycle. This is a process that inhibits the natural, automatic control of sleep, and it leads to insomnia. We will be learning a lot more about this and how to overcome it using CBT methods.

Why Do We Need to Sleep?

Sleep is not an optional extra in life; it is a fundamental requirement. In fact, you could survive for three times as long without food as you could without sleep. Much of what we know about the importance of sleep comes from experiences of people who have taken part in sleep-deprivation experiments. That is, where insufficient sleep, or no sleep, has been taken over successive 24-hour periods. The bottom line is that when people are sleep deprived they are not able to function properly during the day. So, one simple answer to the question ‘What is sleep for?’ would be that the purpose of sleep is to make sure of good-quality daytime functioning. Let’s break that down into three components – physical, mental, and emotional.

We touched earlier on the fact that sleep is required for tissue restoration and for recuperation. During sleep, tired muscles recover and new proteins are synthesized. We also found out that one of the reasons that infants and children need so much

sleep is because they are growing . . . and because they are expending a lot of energy! Equally important, however, is the requirement of sleep for mental purposes. Indeed, among the most striking effects of loss of sleep are inattention, disorientation, and memory problems. This should not be surprising, because sleep loss causes fatigue, drowsiness, and ultimately an inability to remain awake during the day. If we are to be alert and mentally fit in our everyday lives, we need to sleep well. Finally, sleep is extremely important for our emotional functioning. Psychological well-being depends on sleep, too. When we have not had enough sleep it is likely that there will be emotional consequences! Irritability is a common one, and perhaps feeling overly anxious or excitable. It is as if the brain is trying to compensate for its own sluggishness by making us more aroused. Sometimes, though, people experience a more downbeat mood, like feeling rather 'flat', and even depressed, after a period of poor sleep.

It seems, then, that sleep has its physical, mental and emotional processing components, and where sleep quality is impaired, these processes are not able to do their work so effectively.

Normal Variations in Sleep

Having thought a bit about normal sleep I want now to expand on this theme by explaining how sleep patterns can vary, and yet still be 'normal'. There are three main things to say about normal sleep variation. The first is that sleep varies across the night, and in most people across the week. The second is that sleep varies with age and stage of development. The third is that sleep varies from person to person. Let's take each of these topics in turn.

Sleeping Across the Night

We have already learned that sleep is complex, yet it is also orderly. I want to give you a little more detail on those ideas by describing what sleep is typically like across the night. Let us look first of all at the middle part of Figure 4. This is what we call a *sleep hypnogram*. On the left we find the stages of sleep, and reading from left to right along the bottom we find the time line, which has been set here at a notional duration of 8 hours. This is simply to illustrate what happens over time, rather than to imply that everyone should have 8 hours of sleep!

You can see that in the younger adult, wakefulness quickly gives way to sleep and that there is a rapid progression to deep sleep (Stages 3 and 4). This first episode of deep sleep is the longest and deepest of the whole night. The chart has a series of valleys and peaks, with the valleys representing deeper sleep and the peaks lighter sleep. Sometimes these peaks may touch wakefulness. Broadly speaking, deeper sleep dominates the first half of the night and lighter sleep the second half. You can also see that at the end of each sleep cycle there is a period of REM sleep, and that these REM episodes become more frequent towards morning. This explains why people often feel they have been woken out of a deep sleep if woken up early in the night, but may feel that they were simply dozing if woken up towards morning. Similarly, the chances of remembering dreams are greater if you wake during the second part of the night because there is a greater possibility that you were having an episode of REM sleep during that time.

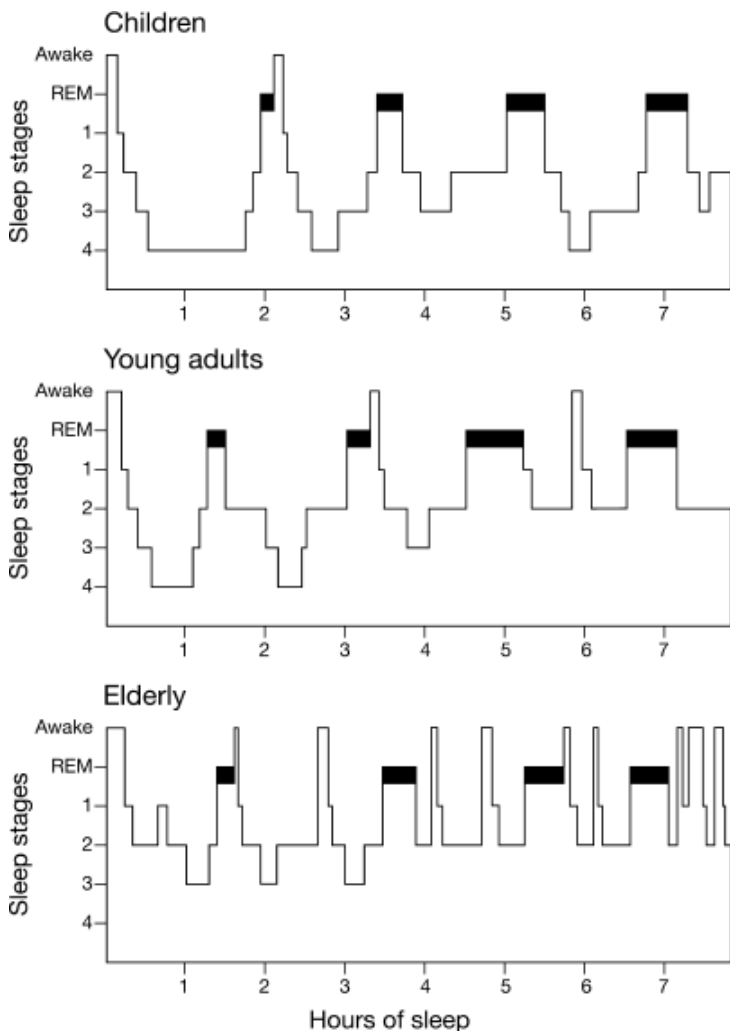


Figure 4 Sleep hypnogram in childhood, young adulthood, and later life

(Figure '1.4' from EVALUATION AND TREATMENT OF INSOMNIA by Anthony Kales and Joyce D. Kales, Copyright © 1984 by Anthony Kales and Joyce D. Kales. Used by permission of Oxford University Press, Inc.)

This pattern is pretty much the same on a night-to-night basis, although it is quite normal to sleep a bit longer at times (for example on weekends) and also to obtain a greater proportion of deep sleep and dreaming sleep on the night after a period of sleep deprivation. For example, if you are up late for a few nights there will be an increased drive towards *recovery sleep*, to repay an element of your sleep debt.

Changes in Sleep Pattern with Age

Everyone knows that our sleep pattern changes across our lifetime. To take an extreme, a newborn baby may sleep 18 hours a day (OK, I know – many do not!), whereas older people may feel fortunate if they can put together a spell of 6 hours' sleep. Figure 5 is helpful here because it illustrates developmental aspects of sleep patterns and provides a guide to what might be expected at different ages and stages of life.

Figure 5 can be related also to Figure 4, which includes a hypnogram of both a child's sleep and an older adult's sleep, to compare with the younger adult we have already considered. Notice that, although the broad distribution of sleep remains similar throughout our lives (for example, we tend to sleep most soundly at the start of our sleep period), maturation and development are associated with some changes in sleep pattern. What I have presented in these illustrations are normal variations in sleep, and this should really lead us to adjust our expectations of sleep according to the age we are at.

Few people would deny that children should go to bed progressively later as they grow up, because over time they need less sleep. We regard that as normal, although it is something that everyone has to adjust to. It is equally normal, however, for older adults to sleep less deeply than younger adults, though this may be less widely accepted as a fact of life. There seems to be a natural *fragmentation* of sleep with age. You will see from both Figures 4 and 5 that the proportion of non-REM sleep that is deep sleep is considerably reduced, and that there is a tendency towards lighter sleep in later life. By comparison, REM sleep is relatively preserved.

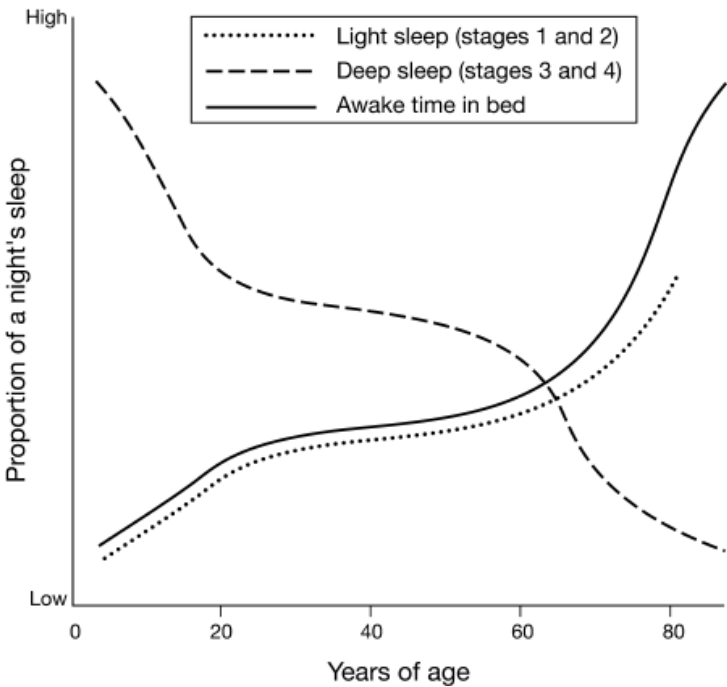


Figure 5 Changes in sleep patterns across a lifespan

(Reproduced from K.L. Lichstein & S.M. Fischer, 'Insomnia' in M. Hersen & A.S. Bellack, *Handbook*

We will see when it comes to the treatment section in Part Two, and you begin to consider your own sleep pattern, that it will be important to take into account your individual *expectations* of sleep. In other words, you will want to consider what sleep problem you have in relation to what might be expected of your sleep at this point in your life, and in relation to what might be a reasonable goal for improvement in your sleep.

Taking Naps

People often ask me if taking a nap is a good thing or a bad thing. There is no straightforward yes or no answer to that. A number of factors need to be taken into account.

First of all let me be very clear in saying that if you feel *sleepy* during the daytime, rather than just fatigued, you should be prepared to take a nap. If you feel you have a tendency to fall asleep involuntarily, then this can be a risky situation. If you are sleepy while driving or operating machinery, you should stop and take a nap for 15 minutes or so. This type of nap, in these circumstances, followed by two cups of caffeinated coffee, is likely to help you temporarily overcome sleepiness.

However, this is only the case in special circumstances where there is a danger that you will fall asleep. In insomnia, sleepiness of this type is not usual. People more commonly feel tired or fatigued and in need of rest, rather than actually sleepy during the day. As a general rule, therefore, if you are not actually sleepy then my recommendation is that you try to avoid taking naps outside the night-time sleep period. Your goal is to become a good sleeper, and we know that sleeping during the daytime can reduce the body's drive for sleep at night. If having a nap is so much part of your routine that you do not want to give it up, then you should restrict the nap to a single period of no more than 15 minutes, and take your nap no later than the early evening. Let me repeat, however, that if you can avoid taking naps, you should do so.

There is no denying that some people can take naps and still be good sleepers at night, but if you are suffering from insomnia, naps will in all likelihood just add to the problem.

As with sleep itself, there are also normal variations in napping, from person to person and across different cultures. Napping is also more common in older adults than in younger adults, in part due to lowered activity levels, and in part to a weakening of the circadian rhythm which controls sleep and wakefulness. Although I am fairly confident that napping does not in itself *cause* insomnia, I am certain that it does not solve it, either.

Good and Poor Sleepers

Some people are familiar with the notion of 'good sleep' or 'poor sleep'. You hear individuals describe themselves as 'poor sleepers' and you hear others describing themselves as 'good sleepers'. But it is also very common for people never to have

thought about this distinction. Or at least this can be so for the good sleepers! This is consistent with the idea of automaticity that I mentioned earlier – we don't really think about sleep . . . until it's a problem.

It is better to think of sleep in *relative* terms, not in absolutes or categories like good and bad. I think this difficulty in differentiating is even clearer when we consider the idea of the 'good night' or the 'bad night'. The truth is that most people have a mixture of these. Admittedly, the good sleeper generally sleeps well, and the quality of that sleep over time is not usually unbroken. However, occasional 'bad nights' do occur. Similarly, the person with insomnia reports sleeping poorly much of the time. I tend to operate on the basis that people with insomnia have at least three 'bad nights' every week, but even they also have nights when their sleep is adequate and refreshes them as it should.

We can see, then, that sleep may be variable for all sleepers, although this variability is much more pronounced in people with insomnia. But why would people who normally sleep soundly have nights when their sleep is disturbed? I think there are three reasons. First, people who normally sleep well do not keep to perfect routines. We live our lives in the real world, and that inevitably involves some variability in how we spend our time. Changes of lifestyle pattern, even temporary ones, have some consequences for sleep. Secondly, the same experiences that contribute to the broken or inadequate sleep of the person with insomnia also affect people who normally sleep well from time to time. Take, for instance, stress. Everyone knows what it is like to lie awake at night with your mind racing. But I think there is also a third reason. It may be that the occasional night of poor-quality sleep, or of diminished sleep, has a useful function. Such occasions may provide the sleep homeostat with the opportunity to 'flex its muscles' and to demonstrate that it is working properly by bringing sleep back into line on subsequent nights.

I can sense that some of you reading this are probably quietly seething about my suggestion that people with insomnia have occasional good nights of sleep! Some of you may feel that you have not had a decent night's sleep for years! I respect your sentiments, and my response here would be that I am talking in relative terms. All I am saying is that you are likely to have *some* nights that are better than others. It is unusual for a person with insomnia to have an identical sleep experience every night. You may wish to have a think about this. Thinking about your sleep in black and white terms is not likely to help you. You need to begin to see the shades of grey.

Others of you may agree that you have a mixture of sleep experiences – and this can be one of the most frustrating things about insomnia. Perhaps you have thought 'Why is it that sometimes I can sleep reasonably well, but I just cannot get myself into a proper pattern?' Never knowing which night is going to give you a reasonable sleep leaves people very frustrated . . . and wakeful! The unpredictability of insomnia can be part of its menace, every bit as much as the relentless aspect of being stuck with a chronic problem.

I want to make one other point here. Just as there are people with larger feet or smaller feet, or with larger or smaller appetites, or faster or slower metabolisms, there are people who seem to be better sleepers than others. Similarly, just as there are people who were short for their age in childhood but became tall adults, so there are people who were poor sleepers when they were younger and better sleepers when they were older. Maybe not everyone is going to be the best sleeper. It is worth considering that it may be part of normal variation that some people will be more

fortunate than others in the strength of their sleep pattern. That is not to say that your sleep cannot be improved – but just bear in mind that it is a fact of life that not everyone is the same.

What Is Sleep Deprivation?

I have mentioned the term *sleep deprivation* several times already. It certainly sounds punitive! Indeed, throughout history, systematically depriving people of sleep has been used as a form of punishment or torture. We have discovered that the body and the mind can survive much better without food than without sleep, so one can only imagine that deliberately depriving people of sleep would have dramatic effects.

The scientific investigation of the effects of sleep deprivation, however, is relatively recent, and much of this work was done in the 1950s and 1960s. It is interesting that even when sleep deprivation experiments were conducted under controlled laboratory conditions, ethical concerns arose about these experiments because of the risks involved. Nowadays this type of research is seldom undertaken, except in very limited circumstances. Nevertheless, it was through such experiments that we began to understand better the functions of sleep. The specific functions of the different stages of sleep became a bit clearer through studies on selective sleep deprivation. For example, not allowing people to have REM sleep led to disorganization of mental processes such as perception, thinking, learning and memory.

But are people with insomnia sleep deprived? As we have learned, sleep is regulated by the body, and even when this regulation is in some way upset, brain mechanisms will not normally allow us to get into a perilous state of sleep deprivation. We have learned that as we go longer without sleep, so the drive for sleep increases. It is more helpful, therefore, to think in terms of sleep loss or ‘sleep debt’ associated with insomnia. Nevertheless, people with insomnia may never quite feel that they have got out of the red and into the black. So insomnia is often associated with a persistent feeling of sleep insufficiency and with daytime impairments to quality of life.

I Could Sleep Anywhere!

You might be wondering why I have put this topic in a section on normal variations in sleep. The reason is that I find there is quite a lot of individual variation in the ability to sleep in different circumstances. Some people can ‘sleep on a pinhead’, in any situation. There are people who seem to be able to sleep right through a long-haul flight, who adjust quickly to new time zones, who can sleep comfortably in a camp bed . . . and so on. And of course there are others who find that they can only sleep under particular circumstances, often only in their own bed, and only if they get to bed by a certain time, and so on. These people sometimes talk about ‘catching the moment’, or say that they become anxious if they get to the stage where they are ‘beyond their sleep’. Most of this I would put down to individual variation – people are different – no more, no less, and in that sense it does not really require any explanation.

What is interesting in insomnia, however, is that sometimes people are actually

able to sleep *better* in unfamiliar environments. As mentioned earlier, this might be because they associate their own bed so strongly with lying awake that they have a kind of conditioned response to it and are unable to fall asleep. Another explanation might be that in an unfamiliar environment they really do not expect to be able to sleep and, because they are not too concerned about trying, they become more relaxed and are able to drop off.

Of course, there are people with insomnia who have problems sleeping in any situation. For some it is simply worse on vacation, or when staying with friends. It is not uncommon in my experience for people to dread, and to avoid, what should be enjoyable times because they worry that their insomnia is going to interfere with their plans. This is yet another example of how intrusive insomnia can be.

Owls and Larks

I am sure we all know what an Owl is: someone who has a tendency to be up at night. This is the kind of individual who comes to life late in the evening and into the small hours, often being energetic and alert at times when most of us are beginning to feel really quite sleepy. By way of contrast, the Lark is someone who is at their best in the morning, preferring to be up early and to make the most of the early part of the day. The Owl is not usually good in the morning, and the Lark is not usually good at night.

People who have one or other of these tendencies simply have a stable phase position that is slightly different from the average. Usually people adapt to their body clock tendency, and often quite like it; they make it work for them rather than against them. Sometimes I see this expressed in their choice of occupation. For example, I have seen a number of people who have been radio presenters, doing late-night shows, and it suits them really well because they are the kind of people who thrive on being up late. It's then quite a different matter if they are put on a morning show!

How Much Sleep Do I Need?

I am sure we are all familiar with the perils of interpreting 'average' figures. If you are a parent you will be familiar with having checked out your child's height and weight against what are called normative values, or *norms* for short, in order to check that everything is progressing as expected. Although norms give the impression that there is a right answer, more careful consideration helps us recognize that in fact we are usually talking about a *normal range*. To take a different example, that of intelligence, the average IQ may be 100, but this certainly does not mean that most people have an IQ of 100 . . . or that they should have. What it does mean is that the normal range of IQ is around 100, so that scores between 90 and 110, or even 80 and 120, would be considered normal.

Table 1 Average sleep requirements at different ages

Age range	Typical sleep requirement
Newborn	A newborn baby may sleep up to 18 hours. At first sleep is taken across the 24 hours with no dominant sleep period. By 4–6 months sleep becomes more consolidated at night.
Young child	Toddlers sleep up to 12 hours at night and normally also sleep for 1½–2 hours during daytime naps.
Child	By the age of 4 years daytime naps will normally have stopped and the child will sleep 10–12 hours at night. This sleep requirement reduces to around 10 hours during the early school years.
Teenager	During adolescence sleep duration is normally around 9 hours. There is some variation in when sleep is taken, e.g. it is common for young people to stay up late and sleep on into the morning.
Young adult	The young adult typically requires 7½–8½ hours' sleep.
Adult	Sleep requirement in terms of total sleep time does not vary greatly during the major part of adulthood. Around 7–8 hours is average.
Older adult	In later life sleep is less consolidated at night, with 6–6½ hours being typical. However, there is a tendency once again to 'top-up' with some daytime naps.

Table 1 provides some information on what is regarded as the normal range of total sleep time at different ages. You can inspect this table and compare for your own age group and see what you think. Of course, even when a value falls outside the normal range, this does not actually mean that there is necessarily something wrong. For example, you might expect that most adult males will be between 5'6" and 6'2" tall, but this does not mean that being only 5'3" represents a problem. Here we have to introduce what is known as the *normal distribution*. That is, outside the middle part of the normal range there is *always* a smaller number of individuals with lower and higher scores. Exactly the same applies to sleep. There are people who are constitutionally particularly *long sleepers* and people who are constitutionally particularly *short sleepers*. Inevitably, these individuals are at the outer margins of the normal distribution, but it does not necessarily mean that their sleep is a problem for them. For example, if a person is a short sleeper, but has no adverse consequences, we would have to suppose that a relatively small amount of sleep is in fact sufficient for that person's needs.

Triggers to Poor Sleep

I want to end this chapter with a brief mention of triggers to poor sleep, because this topic forms a natural bridge to considering insomnia. Everyone has some nights of

sleep disturbance, and often there is an identifiable trigger event or situation. For example, people commonly report disruption to their sleep pattern when there is something important on their mind, when they are sleeping in an unfamiliar environment, or when they experience some kind of upsetting life event. Indeed, it seems that any change in life circumstances has the capacity to disrupt our sleep.

What I am describing here then is a normal process, but equally normal is the tendency for one's sleep pattern to recover. That is, poor sleep is a temporary experience for most people. In the usual course of events we might expect that our normal, restful sleep pattern will be restored once the stressor or the life change is past or dealt with. One of the research challenges that we face in the study of insomnia is why it is that some people recover well and resume good sleep patterns while others develop persistent insomnia.

So let us go on now to explore insomnia in greater depth.

Poor Sleep and Insomnia

So What Is Insomnia?

There are two main diagnostic classification systems that we use internationally to diagnose insomnia. These are, first, the Diagnostic and Statistical Manual of Mental Disorders (DSM), and second, the International Classification of Sleep Disorders (ICSD). These large reference books are what clinicians use to decide if a person has a sleep disturbance, and which type of sleep disorder is present. For our purposes we are most interested in the diagnosis of insomnia, and the separation of insomnia into its various sub-types. Several criteria have to be met for a diagnosis of insomnia.

The Characteristics of Insomnia

In Table 2 I have summarized the main features of insomnia. Insomnia is a *disorder of the initiation or the maintenance of sleep*. That is, a difficulty getting to sleep or a difficulty staying asleep . . . or both! Some people experience sleep that is *non-restorative*; that is, they do actually manage to sleep but they feel that their sleep is not satisfactory, not like a ‘proper sleep’, and they do not feel refreshed afterwards.

To meet the criteria for insomnia the sleep complaint also needs to be present three or more nights per week. In other words, the insomnia has to be a regular feature of the individual’s experience, and in this sense has to be typical of their sleep pattern. The next criterion concerns the severity of the sleep disturbance. Here you will see that it needs to take more than 30 minutes to fall asleep (on a minimum of three nights per week) for the individual to have insomnia of the *sleep-onset* (SOL) type. For the *sleep-maintenance* (WASO) type of insomnia, the difficulty needs to include more than 30 minutes of wakefulness during the night. In my clinical practice, people commonly have *both* SOL and WASO difficulties, that is they have at least 1 hour of wakefulness during the night, either at the beginning or during their sleep period. Indeed, many have 2 or 3 hours of wakefulness during the night, most nights.

Table 2 The diagnosis of insomnia

The complaint	Difficulty getting to sleep or staying asleep; experiencing sleep that is not restorative
Its frequency	Three or more nights per week
Its severity	Sleep-onset latency (SOL) or wake time after sleep-onset (WASO) more than 30 minutes
Its duration	Longer than 6 months
Its effects	Marked distress; impairment socially and/or occupationally; other important consequences

Another way that we sometimes look at the severity of insomnia is to consider the individual's sleep efficiency (SE), which I have defined earlier. A cut-off point of SE = 85 per cent is commonly used in clinical practice and also in research to define significant sleep disturbance. In other words, on average 15 per cent or more of the time needs to be spent wakeful during the night for there to be a diagnosis of insomnia.

The duration criterion I have given in Table 2 is that insomnia must have been a problem for 6 months or longer. The DSM diagnostic system actually requires insomnia to be present for only one month, but my own view is that this is a rather lenient criterion when we are considering *persistent* insomnia. In practice, the majority of people with severe insomnia have had the complaint much longer than that. In my clinical practice it is commonly around 10 to 15 years, as an average, so people usually have no difficulty meeting the duration criterion.

The final criterion in Table 2 refers to the effects of the insomnia upon the individual. This is important, because it is often the consequences of insomnia for the person that leads them to seek treatment. It may be that the effects are primarily social. This could be in terms of irritability or other aspects of interpersonal functioning, or it could be that the effects are more upon productivity in everyday life, in which case concentration and alertness may be problematic. Either way there is usually considerable distress associated with the knock-on effects of insomnia. For the person with insomnia, an unsatisfactory night is often followed by an unsatisfactory day. Sound familiar?

Insomnia Sub-types

We regard insomnia as *primary insomnia* in the DSM system of classification when the disorder meets all of these criteria and there are no known physical or psychological causes of the sleep disturbance. The ICSD classification uses the term *psychophysiologic insomnia* rather than primary insomnia. This is quite helpful, because the name psychophysiologic insomnia suggests a disorder where there is an interaction of mind, behavior, and physiological responses. This state leads to continuing wakefulness in bed and difficulty getting to sleep or difficulty returning to sleep. As I explained earlier on, this type of insomnia is normally verified by PSG assessment. I suspect many of you reading this book will have this type of insomnia – which is good news, because this type of insomnia responds particularly well to CBT.

As we also found out earlier, there is another type of insomnia the suggested name for which is now *paradoxical insomnia*. In paradoxical insomnia, the paradox is that the individual's experience is of having major problems obtaining sleep (sometimes people say that they don't sleep at all), but tests indicate a normal or near-normal sleep pattern. So these individuals are in fact sleeping better and more soundly than they think they do. This discrepancy between subjective and objective sleep is fascinating from a researcher's point of view, and highlights that psychological factors are central to insomnia problems. Indeed, most of the insomnia research groups around the world are paying particular attention to psychophysiologic/primary insomnia and to paradoxical insomnia, as both these disorders tend to persist if not treated effectively with CBT and they do not respond particularly well to sleeping pills.

But what about the circumstances where insomnia may have some connection with a health problem? At times of illness, sleep can become disturbed. There may be several reasons for this, and they may interact with one another.

Illness may affect sleep in a direct way, for example where there are respiratory problems, or neurological problems, or during a fever. Alternatively, it may be the pain or discomfort associated with an illness that disturbs sleep at night. Examples here would include arthritis or muscular problems. Similarly, illnesses that affect the immune system, such as cancer, or the cardiovascular system, such as heart disease, can lead to disturbed sleep and to daytime fatigue. These are all examples of *secondary insomnia*. Other examples of secondary insomnia can be drawn from the psychological and psychiatric field, because insomnia can be associated with mental ill health. Anxiety disorders and depression come immediately to mind. If you are stressed, anxious or depressed, it is quite likely that you will sleep poorly.

It is important to differentiate primary/psychophysiologic insomnia from insomnia associated with another disorder, because insomnia should not in these circumstances be considered in total isolation. On the other hand, if you have a physical health problem or a psychological problem, it does not mean that your insomnia cannot be improved using CBT. It's just that you should pay attention to the *association* between the two and discuss this with your doctor. There is increasing evidence that CBT can in fact be helpful even for secondary insomnia. For example, CBT programs for insomnia associated with physical illnesses have been developed by Dr Kenneth Lichstein at the University of Tuscaloosa, Alabama. Similarly, in Glasgow, my research group has been evaluating CBT for insomnia in people who have had various forms of cancer.

There are some people whose insomnia is largely related to the use of sleep medications. Normally this is in individuals who have been long-term users of what we call 'hypnotic drugs'. This is known as *hypnotic-dependent insomnia*. In these circumstances, the taking of sleeping pills has become the primary problem. The individual with this type of insomnia finds it extremely difficult to stop taking sleeping pills, and when they try the insomnia problem magnifies considerably, leading to them going back on the sleeping pills. If you feel this could be you, you should seek assistance and perhaps follow a structured program to gradually taper off and withdraw the medication. The CBT program described in this book may be helpful to you, but you do need to recognize that sleeping pills themselves can cause some insomnia effects. For example, some medications for sleep cause *rebound insomnia* when you cut them down or stop using them. This temporary worsening of

the problem can be distressing, and in some cases can last for several weeks. I have provided a separate chapter in Part Three to give you more information about sleeping pills.

In summary, then, insomnia is a persistent disorder involving regular sleep disruption and its associated daytime effects. It may occur on its own, or it may be associated with other disorders or other problems. The CBT program described in Part Two should help you with your insomnia, whatever type it is, but you should certainly seek other advice, too, for insomnia when it is associated with physical or mental health problems or with medications.

Other Types of Sleep Problems

I have now introduced the ICSD and DSM classification systems to you, and hinted that there is a wide range of sleep disorders within these classifications. Some of these disorders have similar symptoms to the insomnias that we have been learning about, so it is important that you check out for sure that your problem is not some other type of sleep disorder. To help you with this I have included in Chapter 6 what I call a ‘screening procedure’ to help you rule out some of these other types of problems. I have also written a separate chapter (Chapter 11) in Part Three, on recognizing and managing other common sleep disorders.

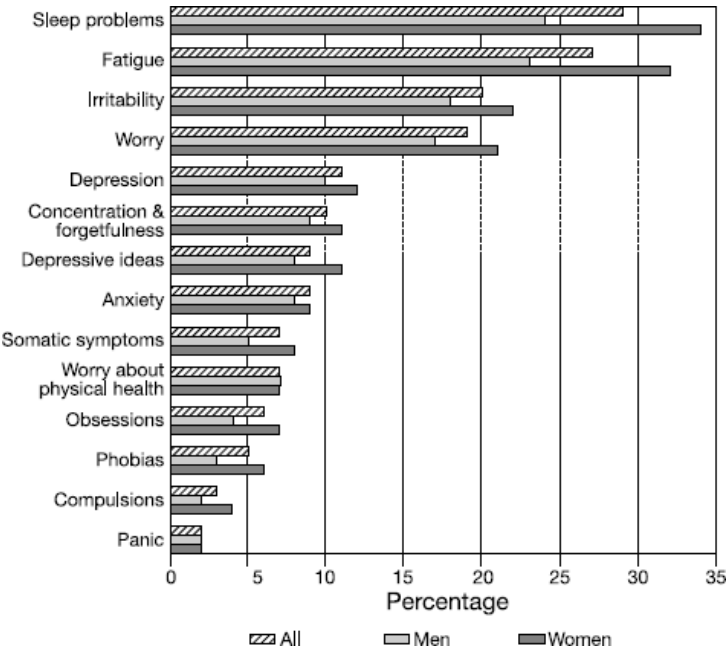


Figure 6 Insomnia is a common problem
(Reproduced from N. Singleton, R. Bumpstead, M. O'Brien, A. Lee & H. Meltzer Kales, *Psychiatric Morbidity among Adults Living in Private Households*. The Office for National Statistics, HMSO, 2001. Crown copyright material is reproduced with the permission of the controller of HMSO and the Queen's Printer for Scotland.)

How Common is Insomnia?

There have been a lot of studies that address this question, to provide us with estimates about how common sleep problems are in the community at large.

Of course you will be familiar with the argument that statistics can be used to tell us anything! It will be of little surprise to you, therefore, when I tell you that there is quite a wide range of estimates where insomnia is concerned. Much depends on the question that has been asked in a particular survey. For example, if people are asked, 'Do you sometimes have difficulties sleeping?', most will answer yes. Likewise, if people are asked 'Do you think you are a poor sleeper?', up to half the general population will say that they are. Another factor which influences the results of such studies is how many people are approached, and whether or not they are representative of the general population. Needless to say, a poorly conducted study is not going to give us very useful information.

The most reliable of these kinds of studies of insomnia are ones that have included questions related to the diagnostic criteria outlined for you in Table 2 (see p. 34). Many such studies have been conducted, and from these we can estimate that around one in ten (10 per cent) of the adult population have persistent problems getting to sleep and/or staying asleep. This figure rises to one in five (20 per cent) of adults over the age of 65. You will see, therefore, that insomnia is a very common problem indeed!

To illustrate this further it is helpful to compare insomnia with some other common problems. In Figure 6 I have presented some information from a large study conducted a few years ago in the UK. This was a study investigating a whole range of health symptoms in the general population. The researchers were interested in finding out how common symptoms of depression, anxiety and so on were in order to help plan appropriate services in primary care (community-based general practice). What is very interesting from the results is that symptoms of sleep disturbance and of fatigue were by far the most commonly reported symptoms among UK adults. This was true for adults of all ages, whether male or female, and regardless of the region in which people lived in the UK, or their ethnic background. The graph demonstrates quite clearly the relative importance of sleep disturbance compared with other complaints that people commonly need help with.

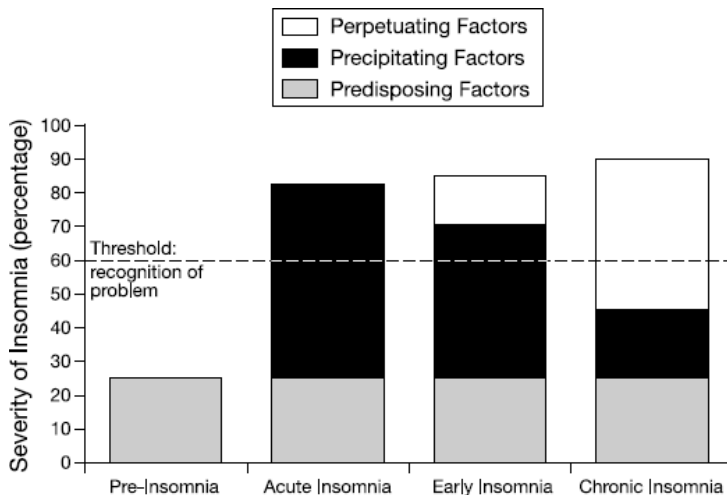


Figure 7 Predisposing, precipitating, and perpetuating factors in insomnia

(Reproduced from A.J. Spielman & P.B. Glovinsky, 'The Varied Nature of Insomnia' in P.J. Hauri (ed.) *Case Studies of Insomnia*, Plenum Press: New York, 1991, pp. 1–15. With kind permission of Springer Science and Business Media.)

So you will see that you are not alone in having insomnia! Far from it. Insomnia is an enormous public health problem, affecting the quality of life of tens of millions of people.

From Occasional to Persistent Insomnia

It remains a bit of a mystery why insomnia might develop from being a short-term problem, or an occasional difficulty rearing its head from time to time, to a persistent or chronic problem.

Dr Art Spielman from the City College of New York has proposed a model of insomnia development and persistence that can be useful here. As we can see in Figure 7, we may assume that everyone has some degree of *predisposition* to develop insomnia, just as one might presume that we have a level of predisposition to develop any other kind of problem. For one individual that predisposition may be higher, say because of a family history of the problem or having a less well-regulated circadian rhythm, or because of a tendency towards anxiety. As the model suggests, however, predisposition on its own would not normally lead someone to develop insomnia. Dr Spielman proposes rather that insomnia develops, first of all, when *precipitating* or triggering factors reach a certain point. We can think of a wide range of factors that might be relevant here, including temporary changes in our sleep environment, or our home environment, or work-related stresses, illness, acute anxiety, and so on.

However, under normal circumstances we would expect that when those temporary, triggering factors diminish again, a good sleep pattern would be reinstated, and the symptoms of insomnia would decline. The model goes on to suggest, therefore, that *perpetuating* factors are required if an insomnia disorder is going to persist. We can imagine that becoming concerned and anxious about sleep

could itself be a powerful perpetuating factor for insomnia. Similarly, in response to such concerns, the person with a developing insomnia problem might disrupt their own sleep patterns further by making behavioral changes to sleep routines. For example, it is tempting to try to catch up on sleep by going to bed early or sleeping in late, but this might just lead to a drop in sleep efficiency rather than a gain if it means that an even longer time is spent lying awake in bed.

Dr Charles Morin from Université Laval in Québec City has extensively researched the *beliefs* and *attitudes* that people with insomnia develop about their sleep and their sleeplessness. This line of research suggests that the sleep *perspective* of the person with insomnia differs from that of the good sleeper, and that this changed perspective can contribute to persistent insomnia. A common example would be that people with insomnia develop the belief that how they feel during the day is largely a result of how they slept the night before. Therefore, they try to anticipate and to control their sleep at night. This thinking pattern becomes associated with anxious, intrusive thoughts about sleep that are *arousing* and so are counterproductive to sleep itself, and also counter-productive to daytime relaxation.

A Model of Insomnia Development

At my own University of Glasgow Sleep Research Laboratory we have been particularly interested in the process of ‘automaticity’ described earlier. You will recall that good sleepers are normally quite unaware of how or why their sleep pattern is so well regulated. It just seems to happen . . . as it were, automatically. They don’t really think much about it. I want to go into a more detailed explanation of automaticity so that you can understand how the *inhibition* of this process could lead to developing insomnia.

Let me start by explaining why it might be that some people go on to develop a persistent insomnia (after a short, acute episode of sleeplessness) whereas others seem to return to their normal sleep patterns. There is a concept in psychology known as *attentional bias*, meaning that our attention is drawn towards objects and events in our environment that are particularly relevant to us. Let me give you a simple example.

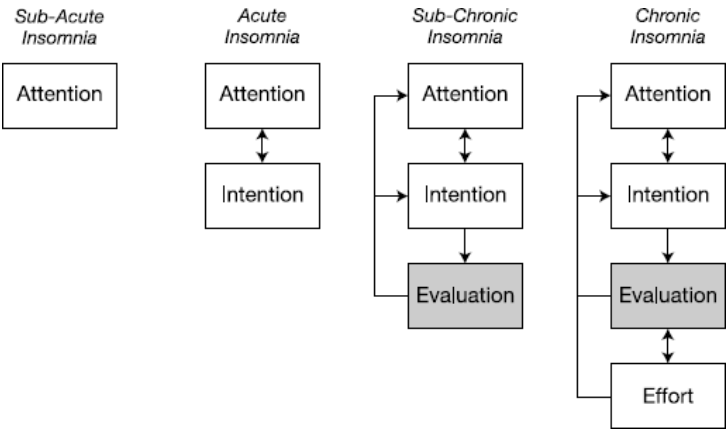


Figure 8 A model of insomnia development

One evening last November I realized that one of my headlight bulbs had failed. During the previous winter I had been stopped by the police because of a faulty headlight bulb and had to pay a fine and, of course, pay to get it repaired. As I drove home (not having the opportunity to get the headlight repaired that night), a distance of no more than 2 miles, I counted seven other cars that had one or other of their headlights not working! My attention was only drawn to this because at the time it was a highly relevant stimulus. I am sure that normally, I would not have particularly noticed. This is what I mean by attentional bias.

In relation to insomnia, we might imagine that during a stressful period our attention will be drawn to the source of that stress (e.g. unemployment) and to its immediate consequences (e.g. financial problems). The acute insomnia that might go along with such a stressful episode may not need any special explanation. At this stage, although we may be aware of not sleeping well, we may not pay much attention to sleep, because our attention is taken up elsewhere . . . and even if we do think about it we may not think it requires a separate solution! However, there may be a transfer of attention to sleep at some point, perhaps if the insomnia gets worse, or if the original stress starts to go away but sleep does not improve spontaneously. Focusing on insomnia can then lead to further problems with sleeping.

You will see in Figure 8 that the development of a sleep-related attentional bias, where none previously existed, may represent the first signs of an insomnia problem . . . the beginning of the end of 'automatic' sleep.

This is a relatively new area of research for us, but we have now conducted attentional bias experiments on over 400 people. We have found that people with insomnia do indeed respond more attentively, even to very subtle cues associated with sleep and sleeplessness. One reason we believe that this theory may be important is that studies on attentional bias in other areas of psychology suggest that these vigilant 'response biases' develop in situations where we feel under some kind of *threat*. For example, people who are afraid of dogs will scan their environment and notice more dogs than people who do not have this phobia. I think that the inability to sleep may be fundamentally threatening because of the biological importance of sleep. To be unable to sleep, or to believe that you are unable to sleep, perhaps sparks off a primitive feeling of threat . . . of danger. If you have always slept well in the past you may feel very threatened by the idea that something you previously took for granted and never had to do anything about, or even had to think about, has now become a problem.

So let's consider what might happen next. You have become more attentive to your sleep. I suggest that this is followed by an *intentional* process. You did not previously pay much attention to sleep, nor did you have particular sleep intentions . . . but *now* it feels as if you need to have a sleep plan. The intentional process is a *planning* process where you begin to think through options and decide on what to do about your developing sleep problem. The intention to sleep, however, is another step along the way to converting what used to be an unconscious, automatic process into a deliberate plan. It is as if you have swapped your car's automatic gearbox for a manual version. You have taken over more of the controls. Consequently, automaticity is inhibited even more . . . and, of course, attention is further heightened because you become even more aware of sleep and sleeplessness in your life.

So now both attention and intention are switched on. You are rapidly losing your sleep's automatic pilot. One possibility is that your plan works out well and that your sleep recovers quickly. In this case, automaticity would be re-established (back on autopilot) and attention and intention would be switched off again. However, if you feel that your sleep is not improving, it is likely that both attentional and intentional processes will now become heightened. I suggest that this *evaluative* process will also directly inhibit the automaticity of sleep, for two reasons. First, scrutinizing sleep performance in this way will focus more (not less) of your attention and intention on it. Second, evaluation introduces an emotional component to the development of insomnia – thinking about success/failure . . . anxieties about sleep not recovering . . . worry about the consequences of sleeplessness . . . concerns about losing control. This last point is significant because the model of good sleep that I am proposing is that good sleep 'control' is automatic . . . yet here we have the development of the incorrect and dysfunctional idea that sleep *should be* under deliberate control.

Finally, in Figure 8 you will see that I am suggesting that an *effortful* process becomes engaged in persistent insomnia. We already have attention, intention and evaluation switched on. What happens now is that we increasingly try to sleep – we put in a big effort . . . we do everything we can . . . leave no stone unturned . . . we use all the resources we can find . . . to *try* to get sleep. This effortful process, I suggest, is also driven by emotion, maybe even desperation. Of course, feedback from the evaluative process is likely to be negative – so attention, intention and evaluation are likely to become heightened further still. Needless to say, sleep effort puts the final nail in the coffin of automaticity. Everything is now anything but automatic. Our work on the development of the Glasgow Sleep Effort Scale suggests that sleep effort is highly relevant to the experience of insomnia. You will learn more about this scale and how to use it later on.

I believe that it is in the *context* of sleep intention and sleep effort that the person with insomnia is likely to do things that will make it very unlikely for good sleep to be able to return spontaneously. With automaticity damaged, the sleep homeostat and the circadian timer become more vulnerable to our emotions and to our behavior. For example, in my experience people with insomnia often make their problems worse, not better, by changing their sleep patterns over and over. Most commonly, they end up spending too much time in bed in relation to the amount of sleep they are getting, so sleep efficiency plummets, and the experience of conditioned arousal in bed increases. Dysregulation of the homeostat and/or the circadian timer is, ironically, perhaps the consequence of people with insomnia trying too hard to put things right.

In summary, then, I think that being *preoccupied with sleep* may represent the *critical* difference between the good sleeper and the person with psychophysiological/primary insomnia. I hope that you can see that there is a lot of work going on around the world in an effort to understand why and how insomnia develops.

The Doctor's Dilemma

It is not uncommon for people with insomnia to feel misunderstood. To a good sleeper there is nothing particularly complicated about getting to sleep, so they may not understand and do not know what to suggest. That's not to say that people do not sympathize. Everyone has experienced occasional bad nights of sleep . . . enough to

know that it is a horrible experience.

More often than not, however, doctors do not really know what to suggest either. Very often people with insomnia are left with the feeling that they just have to live with it. Sometimes it is suggested that they might be depressed, and on occasions this is correct. Sometimes the insomnia will be defined by what it is *not*. For example, 'I don't think you're depressed', or 'I don't think you've got sleep apnea', as if to say that what you *have* got is *only* something else – something else called 'insomnia' . . . which you probably already knew.

I do not mean to be cynical here. I am just reporting what I hear time and time again. But let me provide a corrective to the tone of my comments. I believe that doctors have an extraordinarily difficult task when it comes to trying to give advice about persistent insomnia. Their dilemma is this: they are presented with a distressed person who has a persistent and intrusive complaint, for which they usually have no effective treatment available.

Traditionally, doctors have prescribed medication for insomnia. However, sleeping pills are recommended *only* for short-term insomnia, not persistent insomnia, and their prescription is particularly discouraged in older adults whose bodies are slower to break down the chemical compounds in the drugs. All of the so-called 'hypnotic' drugs are relatively unproven over the longer term, so we do not really know what benefits they have over long-term use. Certainly, many people who take sleeping pills habitually find that they continue to have significant difficulties getting to sleep or staying asleep. The beneficial effects of the medication tend to wear off, requiring either a higher dose or a different drug. In some cases, this can lead to a dependency problem, especially if there are *rebound insomnia* symptoms associated with the medication. Your doctor should be aware of the benefits that can be associated with occasional or very short-term use of various sleeping pills, as well as their limitations and the way they might interact with other medications.

There is really only one other prescription option. That is to prescribe an antidepressant drug, either because there is a suspicion of an underlying depression associated with the insomnia, or because the antidepressant drug happens to have a sedative side-effect when taken at night. The all-too-common practice of prescribing an antidepressant in the absence of depression, however, remains controversial. The most commonly used drugs for this purpose are in a group called the tri-cyclic antidepressants. However, there are few controlled clinical trials of these drugs for the purpose of treating insomnia, and this is a matter of current debate and concern among sleep medicine specialists internationally.

The treatment with the best evidence of success for persistent insomnia is, of course, cognitive behavioral therapy (CBT). The doctors' problem here is that CBT is often not readily available or accessible to their medical practice. Clinical psychologists, or others trained in CBT methods as applied to insomnia, are needed to treat people with insomnia effectively, and these specialists can be a scarce resource.

Fortunately, there is growing interest in the field that has become known as behavioral sleep medicine. The American Academy of Sleep Medicine and other sleep societies worldwide now have specialist sections for those interested in and certified in behavioral sleep medicine practice. So it is expected that assessment and treatment services for people with insomnia will expand both in association with established sleep centres and sleep laboratories, and in the community at large.

In the meantime, hopefully you will find that the CBT methods laid out in this book will work for you.

The Consequences of Insomnia

Simply Having a Bad Night?

As we know, insomnia is a disorder of getting to sleep, a disorder of staying asleep, or a disorder that involves both of these problems. It is important to start this chapter, therefore, with a consideration of the impact that insomnia has on the *experience* of sleep itself.

It is extremely unpleasant to lie awake at night, unable to sleep and hoping either that sleep will come soon . . . or perhaps that morning will come soon. People with insomnia have this negative experience very regularly, and it becomes very demoralizing. Just in the same way as having bad experiences at work, or in a close personal relationship, can lead you to feel low, or helpless, or frustrated, so you can get similar feelings as a result of repeated experiences of not being able to sleep.

If this were a work situation, you might want to change jobs or to retrain. In a personal relationship, you might want to confront the person involved, or avoid them. Usually, when we are stuck in a bad situation we usually want to improve it, to change it, or to get out of it. Similarly, people with insomnia *so much* want things to be different. Have you been caught up in that vicious cycle of sometimes reluctant acceptance, other times fervent efforts to overcome sleeplessness, and then again . . . hopelessness when the insomnia just will not go away? Sometimes people say to me that they become so anxious as bedtime approaches that they cannot bear the thought of yet another night of restless wakefulness.

For all these reasons, I find it a bit odd that the clinical diagnostic criteria for insomnia require that there are also daytime consequences to a poor night-time sleep. This is as good as saying, ‘So what, you don’t sleep at night . . . but you get by – right?’ Personally, I think it *is* a big deal to sleep so badly, without patients feeling they have to justify their insomnia by demonstrating how tired or miserable they feel 24 hours a day. These days we talk a lot about ‘quality of life’ – but do we really just mean quality of waking life? Surely we should recognize that life is made up of daytime and night-time, and that satisfaction and fulfilment in both of these areas is important.

Not infrequently, in the exchange of pleasantries when meeting someone I have never met before, I get a further glimpse of how the world at large views the importance of a good night’s sleep. Once people find out that I research insomnia problems and their treatment, they often say things like ‘I absolutely hate my sleep getting disturbed, it’s the worst thing’ or ‘I couldn’t cope if I didn’t get my sleep.’

Even for good sleepers, having the occasional bad night is pretty much universally a memorable experience! The other response I get, of course, is ‘Oh, that’s really interesting because I have had this problem sleeping for years . . .’

Suffice to say that sleep is such a fundamental thing that not being able to sleep is no trivial matter . . . for any of us!

Sleepiness and Fatigue

Of course it doesn’t end there for people with insomnia. Night-time wakefulness is bad enough in itself, but it normally comes with other baggage. The first item that most people mention is sleepiness or fatigue. When you haven’t slept well at night you are quite likely to feel not so fresh, not so rested during the day.

I have used both these words, sleepiness and fatigue, not because I think they are synonyms, but in fact because I think it is important to understand the difference between them.

Fatigue can be a numbing, disorienting, even depressed kind of feeling – the ‘can’t be bothereds’ if you like. Fatigue is both a physical and a mental experience. Muscle and mind alike seem to resist our best efforts to engage them when we are fatigued. But you can feel fatigued, or perhaps you prefer the term ‘tired’ or ‘weary’ (I think they are about the same thing), without actually being likely to fall asleep.

The tendency actually to fall asleep, particularly to fall asleep involuntarily, is at the extreme end of the spectrum. Fatigue does not mean that we are literally unable to stay awake – that is a different thing. That is sleepiness. People with insomnia are seldom so extremely tired during the day that they cannot help but fall asleep. Excessive sleepiness of this kind is more likely to be the result of sleep deprivation or of a different kind of sleep disorder other than insomnia. Consequently, if patients I see at my clinic tell me that they simply cannot stay awake, that they fall asleep at the drop of a hat even when they don’t want to, then I would most likely commence clinical investigations.

Pervasive and enduring weariness – the feeling that ‘my get up and go has got up and gone’ – now *that* is typical of insomnia.

Problems Concentrating

This feeling that everyday tasks are an effort often reveals itself as a problem with concentration. In psychology, we talk in terms of ‘information processing’. What we mean is that in order to interact with the world, we need to be able to *perceive* (see, hear, sense) what is going on, and we have to be able to *attend* to what is going on. When we are alert and our mind is sharp, recognizing and paying attention to relevant information comes quite naturally. However, when we are tired, information processing becomes more strained, and involves the brain in more work. This is usually what people mean by concentration – that is, the effort to keep focused on something coupled with the sense that a particular task should not normally take this amount of effort.

People with insomnia often comment that they feel they ‘miss things’, that they are not quite ‘on the ball’. It is as if the brain’s information-processing system is not working as efficiently as it should be. Because a fundamental purpose of sleep is to

maintain good-quality daytime alertness, it should not surprise us to find that insomnia has this kind of impact. Sometimes people complain that they are more forgetful because of their insomnia. This may be down to the concentration problems – things were not taken in properly in the first instance. Alternatively, it may be harder to remember, that is to retrieve information from the memory store. It is as if their whole mental apparatus has slowed down. This sluggishness in thinking and reasoning is one of the ways that insomnia has consequences for the day ahead.

Becoming Irritable and Moody

The other main area of complaint associated with the daytime consequences of insomnia is how poor sleep can affect our mood. Have another look at Figure 6 (p. 38). There we have it – sleep problems, fatigue, and irritability – the three most common mental health symptoms.

When we become irritable it is often because we are tired, or our attention span is short, or we are finding it an effort to do something that we think should normally be a simple task. So you will see the connection between our mood and our ability to think clearly. In my clinical work, people often tell me that they are easily provoked, or on a short fuse, if they have had insufficient sleep. This is made even worse if they have a busy schedule during the day and feel that they are failing to perform to their usual standards.

A sense of nervous edginess can also accompany insomnia. This may be part of the body's defence mechanisms against tiredness, by making the person rather hyper-aroused during the daytime, in order to stay alert. We see this clearly in young children, as they become more tired and bedtime approaches. A very similar phenomenon may occur in insomnia. Indeed, it can show itself not only during the daytime, but also around bedtime.

On Becoming Depressed

Does insomnia cause depression? Or is insomnia simply a symptom of depression? I honestly think that both are correct.

There is a great deal of scientific evidence now that insomnia is associated with depression, and that it often comes *before* depression. This may be because insomnia gets people down and that, in time, they are at risk of becoming depressed. Another possibility is that insomnia can be an early stage of depression which may or may not ever develop into a depressive disorder. I hope I am not alarming you here, but it is important for you to understand what clinical research tells us about the relationship between sleep and mood. You might be thinking it is bad enough to have insomnia, without becoming depressed as well. Alternatively, it may be that this helps to explain how you have been feeling over a period of time. The good news is that I believe insomnia is treatable, and if it is a risk factor for the development of depression, it is potentially a treatable risk factor.

It is also clear from research, however, that insomnia is a symptom of depression. That is, people who are depressed usually don't sleep well. There are several illness classification systems that we use to diagnose psychiatric/psychological disorders and, in almost every diagnosis, we find that disturbance of sleep pattern, in some

shape or form, is to be expected. This simply tells us that sleep is one of life's most fundamental processes and that when other things are knocked out of sorts, it is likely that sleep, too, will become disrupted.

If you are depressed it is important to figure out whether the timing of your sleep problem mirrors the timing of your other depressive symptoms. If it does, then there is a good chance that when the depression lifts or is successfully treated, the insomnia will resolve itself, too.

Coping and Everyday Life

Thinking about the consequences of insomnia in terms of symptoms (tiredness, mental slowing, irritability, etc.), however, does not tell us the full story. The main impact of insomnia in the daytime is on how it affects *what we are able to do*. People are concerned about their concentration because they feel they are likely to make mistakes at work. They are concerned about their irritability because it affects family life. It is this interference with daytime functioning in personal, social, and work situations that often leads people to seek professional help. Living with the experience of poor sleep at night may have felt barely tolerable, but add to this these intrusive effects upon daytime quality of life, and you have a problem that is hard to ignore.

Consideration of how we cope during the day, however, raises a very important issue. It is not easy to draw a direct line between sleep and daytime performance. For example, we can and do become irritated for other reasons apart from lack of sleep. It may be hard to concentrate if we are taking on too much, or if we are distracted by things around about us, or if we are in too much of a rush. You will find out that analysis of what we call 'attributions' – the connections between cause and effect that we tend to make – is one of the goals of CBT.

Insomnia and its Effects on the Family

In many respects insomnia is a lonely experience. You may have felt, in the middle of the night, as if you are the only person in the world who is awake! It can also feel lonely in the sense that your bed partner may be a good sleeper; or it may be that you experience loneliness associated with living alone and not having someone to share a bed with.

I find that other people in the family are commonly affected in some way by a patient's insomnia. A common concern of people who have sleepless nights is that they may disturb their partner's sleep, or the sleep of others in the household. So, on top of the anxiety about not sleeping, they have this added worry to deal with. They may lie in bed unsure if they should get up. If they are out of bed, they may be unsure if they will manage to get to sleep if they go back to bed. In this way, there is often a big discrepancy between the sleep pattern of the person with insomnia and others at home – going to bed at different times, falling asleep at different times, waking and rising at different times. This can cause disruption and tension. Indeed, it is very seldom that I see people whose partner also has insomnia. You might think it would be fortunate if insomnia were to be synchronized in this way, because people might then be able to support each other. Then again, that may be the reason why I do not

see them at my clinic!

It is clear, then, that insomnia can be disruptive for other people in the family. It can also cause problems in other ways. There may be limited understanding about insomnia, or sympathy towards it, at home. At times insomnia certainly can be a source of relationship strain. Partners who sleep well may find it hard to believe that you have not slept. Because they have been asleep, it may be natural for them to assume that you have been sleeping too. There is also the fact that the family may have to deal with the consequences of your insomnia in terms of your fatigue and mood.

Effects of Insomnia on Social Life and Working Life

As a general rule, people who have persistent insomnia simply do not feel at their best. Consequently, the other areas that are particularly affected are work and social life.

The work situation can be affected both by concentration difficulties and emotional factors. Things do seem more of an effort after a bad night's sleep. It can be tiring to have to fight off fatigue constantly, and the more we are aware of feeling tired, the more tired we often become. We do not yet have very good research information on how insomnia affects the workplace. However, some recent studies suggest that people with insomnia have more time off work, either through being late in, or through sick leave, than people who sleep well. Insomnia is probably very costly to the economy. There are other costs, too. In clinical practice I sometimes see people pulling back from promotion possibilities, especially those that involve additional responsibility, because they fear that they cannot give their work the attention it deserves. Insomnia causes a loss of potential and a loss of fulfilment that would otherwise be open to these people.

Emotional factors play a part not only in the office or factory, but also in our informal contacts with people in social and leisure settings. Generally, people expect us to behave consistently, and that can be hard if our mood is up and down or if we are on edge through lack of sleep. Sometimes patients tell me that they have cancelled even their most enjoyable commitments and pastimes due to tiredness, and fear of upsetting their friends by appearing distant or temperamental. Everyone is different, of course, but many people with insomnia have social lives that are in some way restricted.

Is Insomnia Doing Me Any Harm?

Insomnia tends to become a persistent or chronic problem if it is not effectively treated and, like many other chronic disorders, can be harmful in the sense that it poses a threat to quality of life. Although insomnia is the kind of problem that people often say they have 'learned to live with', this is usually said with great reluctance. There is often a feeling of having missed out.

Some authorities on insomnia have tried to suggest that it really ends there, that insomnia is an irksome disorder but not one of any great medical consequence. This is not, however, what the evidence tells us. I have already described how insomnia can be a risk factor for the development of a depressive illness. It can also usher in

recurrences of depression in people who have had depression before. There is evidence, too, that physical health problems are more common in people with persistent insomnia, although there is little to support a connection with any specific medical disorder. It may be that insomnia lowers an individual's threshold for ill health, meaning that they may be somewhat more prone to illness. Some studies have even reported lower life expectancy in people with persistent insomnia.

All this goes to show that insomnia is not a trivial problem, and it is well worth trying to overcome.

But I Have Tried Everything Already!

How often have I heard that phrase? How often have *you* said it? In my experience people with insomnia are very resourceful. They are not the kind of people who passively accept a problem, or complain about it to others at every opportunity. Rather, they usually go out and try to find solutions. Medications, herbal remedies, behavioral, mental and a whole host of other self-help strategies are out there. People have often tried some, if not all, of them. How often have I heard desperate people say 'You are my last resort!'

When people have a persistent problem, of any type, it is easy to become dispirited, and it is to your great credit if you are the kind of person who has kept on trying to find a solution. The very fact that you have this book in your hands right now is testimony to the fact that you are determined to overcome your insomnia. Now that you have come to CBT, I hope that this will provide the answer you are looking for.

It is just about time to move on now to practical matters like assessing your sleep, and setting about improving it. But why should CBT offer you an answer when everything else has failed?

There are three possible sources of evidence we can look to, to evaluate the benefits associated with any form of treatment.

The first source is anecdotal evidence, the personal testimony of people who have found something helpful. The logic underlying the power of this type of evidence is 'It worked for me, it might work for you.' This is of course a logical possibility, but there are usually no data to back it up on a large scale. Anecdote, therefore, is not a very reliable source of information because it deals only with possibilities. I am not quibbling with the 'no harm in trying' school of thought, but simply stating that anecdotal evidence should not be considered as concrete proof of the success CBT will have for you.

The second source of evidence comes from marketing. There are many products in the sleep-solutions marketplace (particularly at the pharmacy) that claim to alleviate or cure insomnia. Through being branded as 'health products' they appear to have credibility, and the fact that they are permitted for sale to the general public suggests that they are safe and effective. Again, as with anecdotal evidence, I am not saying that these products do not work, or denying that some people report benefits. What I am saying is that there is not a high level of scientific evidence concerning the likelihood or probability of benefit.

Very few published studies have been conducted on over-the-counter remedies, and those that are available do not reach high scientific standards of evidence. To my knowledge none of these products has been evaluated in a properly conducted

clinical trial. Such research work, independent of the interests of the companies concerned, is certainly required. We also need to find out if the improvement in sleep associated with these products is of real clinical importance in treating insomnia. A final point about over-the-counter products is that they tend to be very expensive, even compared to recently developed licensed medications.

The third level of evidence is what we rely on in scientific study to establish the effectiveness of a treatment for any health condition. This is where products and procedures are systematically tested in *randomized controlled trials* (RCTs). It is normal to test first against chance variation over time – that is, the possibility that some people will improve anyway, at random; and secondly, to test against the placebo effect – that is, the possibility that some people will improve simply because they believe a treatment will work. The amount of true benefit associated with a treatment, therefore, is established only when the effects of time and placebo have been carefully excluded. It is on the basis of studies such as this that I am able to recommend CBT as the best treatment for persistent insomnia.

Cognitive behavioral techniques, and component parts of CBT, have been extensively evaluated using RCT methods over the past 25 years. Around 60 trials have been conducted worldwide and have been published in the scientific literature. Data from these trials have also been pooled to determine the overall probability of benefit associated with CBT. The good news is that CBT is regarded, on the basis of this large body of evidence, as the *treatment of choice for persistent insomnia*. Unlike sleeping pills, the benefits are not short-term. Two-thirds to three-quarters of people with persistent insomnia have been found to obtain lasting benefit from CBT.

PART TWO

Overcoming Insomnia and Becoming a Good Sleeper

Introduction to Part Two

This CBT program is based on many years of careful research work, conducted in general medical practice settings. It is a program for people with severe and enduring insomnia, and my aim is to pass on to you a clinically proven and effective treatment. Let me explain what is involved and how the chapters in Part Two of this book will help you to follow the program.

You are best to think of this as if you are attending a course of treatment. Instead of me acting as your therapist, the book, I hope, will do it instead! Certainly I have written it for you with this in mind. Over the next six chapters (Chapters 5 to 10) we are going to work towards overcoming your insomnia. Here is the plan!

Chapter 5 is about assessing your insomnia problem.

In Chapter 6 I am going to review some of the facts about sleep and insomnia that you learned about in Part One of this book, as well as adding some new information.

In Chapter 7 I am going to explain about sleep hygiene and relaxation methods, and how you can put these into practice.

In Chapter 8 we have the big challenge coming up – scheduling a new sleep pattern for you.

In Chapter 9 I want to focus on the ‘racing mind’. Does that sound like a familiar problem?

Finally in Chapter 10, I am going to show you how to put it all together, and keep it all together!

Table 3 The CBT program

Topic	Week	Chapter
Assessing your insomnia problem	1	5
Understanding sleep and insomnia	2	6
Sleep hygiene and relaxation	3	7
Scheduling your new sleep pattern	4	8
Dealing with a racing mind	5	9
Putting it all together	6	10

Going back to that idea of attending a course, I have listed the CBT course program in Table 3. You will see that I have set it out week by week. That is because I want you to become familiar with each part of the treatment, and to develop the

necessary skills as you go along. I will introduce treatment elements a step at a time. This is to give you the chance to understand them and to put them into practice. So here is a warning: this program is not meant as a 'pick-and-mix'. I will be able to help you most if you complete the whole treatment program the way I have laid it out, over the course of 6 weeks. Being realistic, I know that I can't actually stop you jumping ahead – but just remember that my advice is that you go through the program with me, stage by stage, chapter by chapter.

Let me also say that it is not just a matter of reading. The book is more like a manual – a *what* to do, *how* to do it, *when* to do it, kind of book if you like. Hopefully, you will also become clearer about *why* you are doing what you are doing. Try to give your reading and preparation for CBT some priority time so that you can make the most of the advice I can give you. If you were really attending a CBT course you would be setting aside a couple of hours for that at least. Plus you would have the 'homework' aspect to it, too, because you would be putting into practice what you had learned. You need to follow this same kind of discipline here if you want to get the most benefit from the book. Have a think now about when you can set aside time each week to concentrate on the material you need to cover.

I think of your task as a cycle of reading, understanding, applying and reviewing . . . as you go along. It's good to go back over things again and again to make sure that you really understand. As you put things into practice you will understand even better. By reviewing how things are going with your sleep pattern, you will be giving yourself feedback on your success in applying what you have learned and will have the opportunity to check if you are following each part of the CBT program correctly. On the next read-through, perhaps you will pick up on something else. I'm sure you get what I mean – the bottom line is that this course requires quite a bit from you. Keep going round that cycle.

Another practical point – don't just rely on your memory! Get yourself a notebook where you can jot down important points from time to time. I will refer to using your notebook as we go along . . . so be prepared.

Having said all this, I don't want you to be too daunted. This is a very practical program using plain English to introduce CBT techniques that have been found to be effective for insomnia.

Assessing Your Insomnia Problem (Program Week 1)

Introduction

This is the first week of the CBT program, and we start off with assessment. In CBT, assessment and treatment go hand in hand. You will see as we go through the program that you are often pausing to assess some aspect of your sleep, or some aspect of your behavior or attitude concerning sleep.

The chapter starts by helping you with the important task of gathering your personal sleep history. We need to consider what your sleep pattern has been like over the years, and how, and possibly when, your insomnia developed. We also need to be sure that what we are dealing with is indeed insomnia, and not some other type of sleep disorder. I will introduce you to the Sleep Diary, an invaluable tool in CBT for insomnia, and I will coach you in how to use it. Bit by bit you will be able to form a clear picture of what kind of shape your sleep pattern is in. We will then move on to a consideration of your goals – that is, what you are hoping for as a result of successful treatment. Finally, this chapter concludes with help for assessing your motivational state – your readiness for CBT.

Aim

The purpose of this chapter is to provide you with the means to assess the nature and severity of your sleep problem and its impact upon your life.

Your Personal Sleep History

Those of us who work in clinical practice talk about ‘taking a history’. What we mean is finding out as much as we can about a problem, about how it shows itself day to day, and about its development over a period of time. In simple terms, the idea is to obtain an accurate picture. Here, of course, we are concerned with your *personal* sleep history.

Obviously I cannot take your history. What I can do, though, is to provide you with a structure that will help you to discover your own sleep history. You will see there is a format for this in Table 4 (pp. 68–70). This is what is called a *semi-structured* approach because it guides you to general areas of content (left column) and to ask yourself ‘starter’ questions (middle column) at first to focus upon the

issues of interest. In the right-hand column I have given you some further questions to answer to go into topics in more detail.

Is now a good time for you to work your way through your sleep history? Now where did you put that notebook? You will find a notebook really helpful throughout the CBT program, because writing things down does help us to think about them and to figure them out. In doing your history you may find you have to check out some information with other people – perhaps a partner can recall important times or dates or events, or a parent or brother or sister may remember further back when you were younger. Your notebook is also going to be helpful when it comes to reminding you of key points in the program, and of the decisions and plans you have made for your sleep. Oh, and before I leave the topic of notebooks, don't get too hung up on being neat and tidy. Your notebook is . . . for taking notes. It doesn't need to be a thing of beauty or a work of art. Use your notebook as a working document or a working file – if you really want to have a finished product at the end of the day, you can write that up later from your notes.

You can see in Table 4 that the sleep history begins with your sleep pattern, its quality and how it is affecting you. At this stage try to think of these matters fairly generally, because later I will be introducing the use of a Sleep Diary that will help you collect some of this information in a more systematic way. Next in Table 4 you will see you are moving on to consider how and when your insomnia developed over the years and how you used to sleep when you were younger. As I mentioned, some of this might need to be discussed with other people who have useful information to share. Moving on again, spend a bit of time considering whether other people in your family have had sleep problems, and whether their problem is like your problem, or different from it. It's important next to take into account your general health and psychological well-being, and how such factors might be associated in some way with poor sleep. Finally in Table 4 I have asked you to think through and note down things you have tried before to improve your sleep, for how long you tried them, and how well you think you tried them. This is important in itself to have as a record. It is also important because your past experience will have an effect upon your expectation of any future therapy (including the one in this book!).

Checking Out Insomnia and Other Sleep Problems

There is one other part of your sleep history that is important, although I have put it separately in another table for you. These are questions that refer to other types of sleep problems (Table 5 on pp. 72–3). That is, sleep problems other than insomnia. The CBT methods that I will describe in this book are *only* for the treatment of insomnia, so it is important for you to consider the possibility that you may have a different type of problem instead, or as well. In clinical practice I call this a *screening procedure*, because it is simply a way of identifying possible problems.

Table 4 Your personal sleep history

Content Area	Starter Question	Further Questions
Presentation of the sleep problem Pattern	What is the pattern of your sleep on a typical night?	How long does it take you to fall asleep? How often do you wake up? How long are you awake for during the night? How much sleep do you get? How many nights each week are like this?
Quality	How do you feel about the quality of your sleep?	Is it refreshing? Is it enjoyable? Is it restless? How would you describe it in your own words?
Daytime effects	How does your night's sleep affect your day?	Do you feel tired? Do you feel sleepy? Do you have problems concentrating? Do you feel irritable? What do you think your insomnia does to your day? When are your worst times of the day?
Impact on your life	How does your insomnia affect your quality of life?	What consequences does insomnia have for you?

Development of the sleep problem	Do you remember how and when your poor sleep started?	<p>What are you not able to do because of insomnia?</p> <p>How would things be different in your life if you overcame your insomnia?</p> <p>What were the events and circumstances then?</p> <p>What were the important dates and times?</p> <p>How has your sleep changed over time?</p> <p>Has anything happened that has made it worse?</p> <p>Has anything happened that has made it better?</p>
Lifetime history of the sleep problem	Did you used to be a good sleeper?	<p>How did you sleep as a child?</p> <p>How did you sleep as a teenager?</p> <p>How did you sleep as a younger adult?</p> <p>Were there previous episodes of poor sleep?</p> <p>Dates and times?</p> <p>Did these past episodes resolve? If so, how?</p>
Family history of sleep and sleep problems	Do other people in your family have problems sleeping?	<p>Do either of your parents have sleep difficulties (now or in the past)?</p> <p>What about brothers and sisters?</p> <p>What about the extended family, including grandparents?</p> <p>Does anyone have problems that are similar to your problems sleeping?</p>

General health and medical history	Have you generally kept in good health?	Have you had any major illnesses? Have any health problems been persistent ones? Dates and times? Have there been any recent changes in your health?
History of psychological well-being	Are you the kind of person who usually copes well?	Have you had any psychological problems? Any problems with anxiety or depression, or with stress? Dates and times?
Current and previous treatments for insomnia	Are you taking anything to help you sleep?	What (if any) medicines are you taking now to help you sleep? What have you taken in the past? Dates and times? Are you taking anything you have bought over the counter? What sorts of things have you tried to do yourself to help you sleep? What have you found that has worked and hasn't worked?

Let's start with insomnia itself, so you understand what I mean. Look back to Table 2 (p. 34) on the diagnosis of insomnia, because this gives us a way of screening for insomnia itself. Persistent insomnia is usually defined as taking more than 30 minutes to fall asleep, or being awake for more than 30 minutes during the night, on at least 3 nights per week, for at least 6 months. If you check what you have noted

down already in your sleep history you can see if you ‘screen positive’ for persistent insomnia. In other words, your problem is at least at this level of severity. But you should also have a look back to Part One where I described the main types of insomnia that might be helped by CBT. These were psychophysiological insomnia (sometimes called primary insomnia), paradoxical insomnia, and also insomnia associated with medical or psychological problems (sometimes called secondary insomnia). Although I have included this last type you will see that it also appears in Table 5 because you should screen for the possibility that physical or mental health problems need attention in the first instance.

Turning then to Table 5, it is important that you consider whether or not you might screen positive for *any other type* of sleep disorder. Just proceed as you did with the first part of the sleep history. The left column lists the different types of sleep disorder, the middle column gives you a starter question, and the right-hand column asks you some follow-up questions. Keep a note of anything relevant in your notebook. To take the example of sleep-related breathing disorder (SBD), you will see that there is first a question about snoring. That is because most people with SBD snore. However, lots of people snore but do not have breathing pauses that affect the quality of their sleep. It is breathing pauses and daytime sleepiness that are particularly important here, because they raise the possibility of a disorder known as obstructive sleep apnea (OSA). The questions on the right would help you to explore these details further.

My suggestion is that you work through this part of the sleep history and, if you think that you may have any of these other sleep problems, then you should read Chapter 12. I have added this chapter to the book specifically to address such issues and to give you advice on what to do. However, if you think that none of these screening questions is relevant to you, you can simply carry on to the next section.

Table 5 Other disorders of sleep

Content Area	Starter Question	Further Questions
Screening for sleep disorders other than insomnia		
Sleep-related breathing disorder (SBD)	<i>Are you a heavy snorer?</i>	<p><i>Do you have interrupted breathing during your sleep?</i></p> <p><i>Does your partner say that you sometimes stop breathing?</i></p> <p><i>Do you wake up gasping for a breath?</i></p> <p><i>Are you excessively sleepy during the day?</i></p> <p><i>Do you fall asleep in the day without wanting to?</i></p>
Periodic limb movements in sleep (PLMS) and restless legs syndrome (RLS)	<i>Do your legs sometimes twitch or jerk or can't keep still?</i>	<p><i>Is it difficult to get to sleep because of muscle jerks?</i></p> <p><i>Do you wake from sleep with sudden jerky movements or feeling the need to move your legs?</i></p> <p><i>Do you have to get out of bed and pace around to get rid of these feelings?</i></p> <p><i>Are you excessively sleepy during the day?</i></p>
Circadian rhythm sleep disorders – delayed sleep phase syndrome (DSPS)	<i>Do you tend to sleep all night but at the 'wrong' time?</i>	<p><i>Can you sleep well enough but only if you stay up very late?</i></p> <p><i>Are you alert and not sleepy until a long while after normal bedtime?</i></p> <p><i>Are you sound asleep at normal waking time and can sleep on for hours?</i></p>

Circadian rhythm sleep disorders –
advanced sleep phase syndrome
(ASPS)

Can you sleep well enough but only if you go to
bed very early?
Are you very sleepy if you try to stay up until
normal bedtime?
Do you wake very early, bright and alert and no
longer sleepy?

Parasomnias

Do you have unusual
behaviors associated with
your sleep?

Do you sleepwalk?
Do you sleeptalk?
Do you have confused behavioral episodes
during the night?
Do you have night terrors when you are very
distressed but not properly awake?
Do you grind your teeth at night?
Do you sometimes act out your dreams?
Do you have nightmares?

Narcolepsy

Do you sometimes just fall
asleep without warning?

Do you have sudden 'sleep attacks'?
Is it impossible to resist falling asleep during the
day?
Do you have collapses or extreme muscle
weakness triggered by emotion?
Do you have hallucinations or odd sensations
when you fall asleep or when you wake in the
morning?
Do you sometimes feel paralyzed and unable to
move when you wake from your sleep?

Using a Sleep Diary

Sometimes insomnia can be difficult to put into numbers. Ask yourself the question 'How long was I awake last night?' It's not just that it is hard to remember exactly. There is quite a challenge in adding up all the bits of time involved. Also, you may

not quite think of your sleep in that way. You may reflect more generally on a ‘good night’ or a ‘bad night’, depending upon how you feel in the morning. This is because the *quality* of your sleep is just as important as its *quantity*.

Although it is not an easy task, I believe it is important for you to try to measure *both* your sleep pattern and your sleep quality as best as you can. This is where the Sleep Diary comes in. I have prepared a diary for you that leaves space for seven nights on the one sheet (Figure 9). You should photocopy this so that you can use it over and over while you follow the treatment program. You will get better at filling in the diary with practice.

Your Sleep Diary will help you to see where problems lie for you. For example, is it a difficulty getting to sleep, or a difficulty staying asleep, or is it both? The diary will also help you look at your sleep across the week. You will be able to see any variability in sleep pattern or sleep quality from night to night, and to compare ‘good nights’ with ‘bad nights’. Most importantly of all, the diary will also help you to assess changes in your sleep as you put the CBT program into practice.

Have a good look now at Figure 9. You will see that the diary starts by asking you about your wake-up time and your rising time. These are the times when you finally woke up in the morning and when you finally got out of bed. Next you have to think back and note down your bedtime, and also when you put your light out the previous night. Then there are four questions about your sleep pattern – how long it took you to fall asleep, how many times you woke up in the night, how long in total these wakings lasted, and how long you think that you slept altogether. There is a bit of arithmetic involved! But hopefully you can make a reasonable estimate of all of these important dimensions of your sleep.

Week Beginning _____
Measuring the Pattern of Your Sleep

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
1. What time did you wake up this morning?							
2. What time did you rise from bed this morning?							
3. What time did you go to bed last night?							
4. What time did you put the light out?							
5. How long did it take you to fall asleep?							
6. How many times did you wake in the night?							
7. How long were you awake during the night?							
8. How long did you sleep altogether?							
9. How much alcohol did you have last night?							
10. How many sleeping pills did you take?							
Measuring the Quality of Your Sleep							
1. How well rested do you feel this morning?	0 not at all	1 moderately	2 moderately	3 very	4 very		
2. Was your sleep of good quality?	0 not at all	1 moderately	2 moderately	3 very	4 very		

Figure 9 Your Sleep Diary

It is always a good idea to take note of anything that might have affected how you slept. You will see that I have put in questions about any alcohol or sleeping pills you took the night before. The pills section is easy – you can just put in the number you took, or the milligram (mg) dose if you prefer. For alcohol, I suggest you count in common ‘units’ where one small glass of wine, one standard measure (single) of spirits, and one half-pint or regular bottle of beer = 1 unit.

Finally, there are two questions on measuring the quality of your sleep. I have made this into a simple scale so you can just put in a number (0, 1, 2, 3 or 4) to represent how you feel about your sleep now that you have woken up. The higher the score, the better the quality of your sleep. After a while the numbers will begin to

mean more to you!

Hopefully the diary is quite simple to understand. If you think it looks a bit complicated, I am sure that once you try it out over a few nights you will soon get the hang of it. I have made a few other suggestions in Box 1 (p. 77) that will help you to make the best use of your Sleep Diary. Read through these carefully.

So What Shape Are You In?

Before you even start using the Sleep Diary I would suggest that you have a think about what you expect your diary answers will look like. You might want to take a photocopy of the diary, mark it 'My Diary Estimate' and fill in just one column (any column) to represent what you think your sleep pattern and quality is like on a 'typical' night. You can then go ahead and start recording your sleep day by day using the diary, and compare what you find after one week with your diary estimate. You can also have a think back to your sleep history and what you thought then about your sleep pattern.

Box 1 Some tips on completing your Sleep Diary

DO

- complete your diary within 1 hour of rising from bed
- write down times to the nearest 5 to 10 minutes if you can
- double-check your answers

DON'T

- clock-watch during the night
- worry about it! (it is just a record of your sleep)
- make up answers (it's OK to leave it blank if you forget!)

Why am I suggesting using a diary? This is because, in my experience, people often learn quite a bit just from keeping a diary. There may be things that confirm your expectations, and also things that are not what you expected at all! All of this is useful information when it comes to planning your new sleep schedule and adopting the right frame of mind to overcome insomnia.

I want you to *keep your diary from now on right through the treatment program*. Let me tell you right now that you will find this a challenge! It is so easy to forget . . . and even a couple of minutes set aside to fill it in may seem like too much at the start of a busy day. Nevertheless, it is well worth the effort and it is very important. Have another look at the tips in Box 1. I hope they help.

In science, we talk of 'establishing a baseline'. This means that we try to establish what the problem shapes up like over a period of time. We can then be more sure of whether or not we are making a difference through our intervention. Your Sleep Diary is a record of your problem and a record of your progress in overcoming your insomnia using CBT.

So, what shape are you in? I think your Sleep Diary will give a better picture of that than your general estimate. See what you think!

What Are Your Goals?

It is one thing to come to know what a problem shapes up like. It is another to decide what you are looking for as a solution. What are your goals in using this book? What are you trying to achieve through CBT? I want to think this one through carefully with you, because your success in overcoming your insomnia will be partly determined by your goals. This is an important statement, so let me repeat it:

Your success in overcoming your insomnia will be partly determined by your goals

If your goal is to sleep 8 hours every night, then by definition you would be unsuccessful if you achieved only 7½ hours, or if you did achieve 8 hours but only on some nights. It seems to me that when it comes to numbers, you are best to pitch at the most *achievable* figure that is *acceptable* to you. This is one way that the diary comes in handy, because you can find out what shape you are in at the start. As you go along, of course, you can always revise your goals. I think it is better to get encouragement by making improvements towards your (final) goal, by recognizing progress you have made as compared with your baseline. I would advise you to set realistic goals at all times. If you have a handicap of 20 in golf, hoping to play off 10, would you rather be encouraged at achieving an interim goal of 15 or discouraged because you are only half way there?

With sleep, though, as we know, it is not just numbers. What if your goal is ‘just to get a decent night’s sleep’? I have heard this so often . . . and no, it doesn’t seem like too much to ask. However, the problem is that it is hard to know how you go about scoring this kind of goal. How do you define ‘a decent night’s sleep’? How do you know when you have achieved it? I think you need to find a way to make your goal *measurable*. In Table 6 I have given you a list of the categories of treatment goal that I commonly see at my clinics. Which of these, or which mixture of these, best describes the situation with your sleep?

Table 6 Different types of treatment goal

Common goals in insomnia patients want to achieve . . .	They say things like . . .
More sleep	'I'm simply not getting enough sleep. I hardly sleep at all and that's no good.'
A more satisfying sleep	'I feel my sleep quality is really the problem . . . even when I do sleep, I never feel I've slept properly.'
A more restorative sleep	'I want to be able to feel I can cope with the day . . . to feel rested and not tired all the time.'
A more reliable sleep	'What sleep pattern? I don't have any pattern, that's the problem.'
A more normal sleep	'I just want to get 7 or 8 hours . . . just like other people seem to manage.'

You may feel that your first requirement is for *more sleep*. You feel that you are not getting enough of it. You may wish to fall asleep more quickly, to stay asleep without waking, or just to get a greater amount of sleep. Alternatively you may feel that the sleep that you do get is not of acceptable quality and so you are seeking a *more satisfying sleep*. Here you want your sleep to be a nice sleep, an enjoyable experience. Another possibility is that you are concerned mostly about the consequences of your sleep. You may feel, therefore, that you need a *more restorative sleep* to enable you to function properly in the daytime. On the other hand, if you feel your sleep pattern is out of control, you may be concerned about the inconsistency of your sleep. This is what I mean by talking of the goal of a *more reliable sleep*, a pattern you can rely upon to be OK. Finally, you might think in terms of wanting to have a *normal sleep*. This might be a goal of sleeping in the way that other people seem to sleep, or in the way you yourself were able to sleep in the past.

The message is to know your problem, but also to know your goals. Write down your goals in your notebook now . . . but, because your goals in overcoming insomnia need to be considered carefully, I strongly recommend that you are always prepared to come back to these key questions:

- Is my sleep goal *achievable*?
- Is the achievable sleep goal *acceptable*?
- Is my achievable and acceptable sleep goal *measurable*?

Assessing Your Readiness for Change

The final thing I want you to assess before we move on is your *motivation for change*. Don't be offended. It's not that I doubt your commitment to try to improve your sleep. I know that you are likely to have tried loads of things before. In fact, that

is one of the reasons I mention motivation. It can be hard to try again after many disappointments, and perhaps you have limited confidence that anything will ever work.

It is particularly important that I ask the question ‘are you ready?’ with a CBT program, because CBT can be very demanding of you. I tell you, even to keep up with those diaries will at times feel tiresome! You are also going to face some tough decisions about your sleep, and about your beliefs and attitudes concerning your sleep. There will be things to do . . . and things to give up.

Then again, changes take time so please be gentle with yourself if you do not find improvements occurring as quickly as you would like. They say that ‘old habits die hard’ and you will need to coax new habits to develop! Keeping motivated is the key to feeling encouraged and to achieving permanent improvements in your sleep pattern.

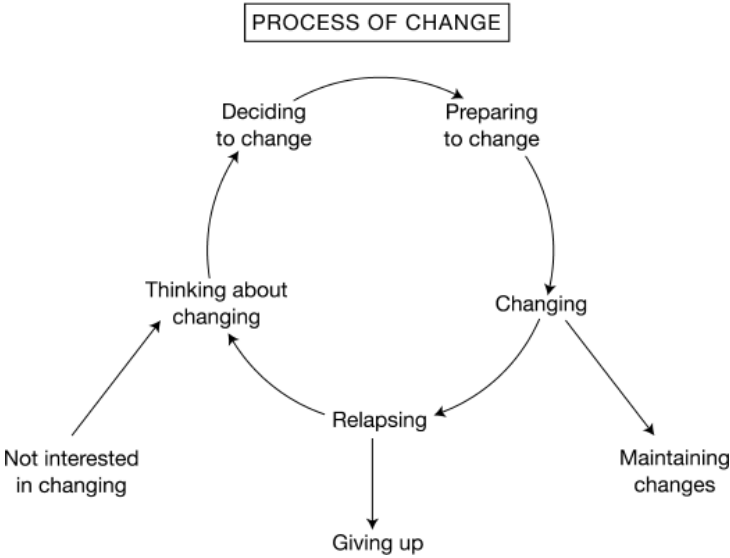


Figure 10 Considering your motivational state

The diagram in Figure 10 shows us the process of changing a situation. Where do you think you are on this wheel at the moment? First you have to decide whether you are interested in addressing your sleep problem at this particular point in time. If so, are you thinking about starting the course of CBT treatment, or have you already got to the point of making that decision? Perhaps there are some practical obstacles that will delay you if you don’t deal with them just now.

If all is set fair to progress, then what are the necessary preparations? So far, that will have involved reading Part One of this book, working on your sleep history, photocopying your Sleep Diary, and so on. If you are on your way to the ‘changes’ stage then you will have recorded your sleep estimates, you will have started keeping your diary, and you will have carefully thought through and written down your sleep goals.

I want you to come back to this diagram from time to time as you go through the

program and ask yourself the question ‘Where am I on this wheel at the moment?’ Your motivation will come and go; that is to be expected. So do expect it, and recognize it, and then try to correct it. You will see in Figure 10 that mention is made of relapsing. *Relapses* are times when you experience a strong feeling of disappointment either with the program, because you hoped it would have worked better or more quickly; or with yourself, because you felt unable to follow a part of the program or you forgot to do it. You may find that your sleep improves but then gets worse (relapses) again. These are all examples of times you may think that there is no point in continuing. Please don’t let such relapses discourage you. The best thing to do is to get back to the CBT course and try again.

I want to reassure you that I am telling you this because it is quite normal for the process of sleep change to be an uneven path. Try to think of this as normal and you will find it much easier to deal with. Let me also tell you, though, that you may never have had a better chance of sorting out your sleep problems than this CBT program! Remember it is an evidence-based approach, which means it has worked for many, many others who have seen it through. At the end of the day your goal is to maintain all the changes that you are able to put into practice so that your new, good sleep pattern becomes permanent.

It is now the end of Week 1 of the program . . . but before moving on to Week 2, you should have completed one full week of Sleep Diary recordings.

Understanding Sleep and Insomnia (Program Week 2)

Introduction

I can just hear you thinking that we already covered this in Part One of the book. You are correct. Don't worry, I am not going to repeat all that again. However, I make no apology for starting off this first of five treatment chapters with a review of some of this information. Let me tell you why.

<i>What we know and what we feel are not necessarily the same thing.</i>
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I would encourage you to read this statement over a few times. It is very important. Let me give you an example. Phobias are interesting problems – we call them ‘irrational fears’ precisely because the person with a phobia really knows that the thing they fear is likely to be quite safe. Of course, they do not feel that it is safe when they are faced with the situation! Most people who are afraid of spiders, or thunderstorms, know that it is their *fear* that is the problem. They know when they focus on the facts that the spider is unlikely to hurt them, that the thunderstorm is not directed at them . . . but what we know (intellectually) and what we feel (emotionally) are not necessarily the same thing.

What has all this got to do with insomnia? Well, in Chapters 1 to 4 you learned a lot about sleep, and about insomnia and its consequences. I would hope that by now you *know* more than you did before you started out. But can I ask you if you *feel* any differently about your sleep or any part of your sleep problem? Do you feel any differently about yourself, as a poor sleeper?

For information to be of any real help to you, it has to change not only the way you think but also the way you feel. In Chapter 5 you began to assess your sleep pattern. Your Sleep Diary will have given you detailed information to consider on how you are sleeping at present. Now you need to weigh up that Sleep Diary information alongside what you have learned from Part One of the book.

This part of the CBT program is partly about encouraging you to have an open mind. Perhaps you need to form a fresh view about some things relating to sleep or insomnia? And to let the facts affect how you feel? I am also counting on the possibility that some of you reading the book will be thinking that you already knew almost everything I have said. But my comment applies to you, too, perhaps even more so. Read the statement above once more. You may already know a lot – my

challenge to you is to use this information differently.

Aim

The purpose of this chapter is to remind you about normal sleep and about sleep disorders and their effects, *and to use this information to make a difference to how you think and feel about your insomnia and about yourself.*

Your Starting Point – A Quiz

Let's see how much you remember from Part One. In Box 2 I have put together a quiz to test your knowledge. It is to get you thinking.

There are two ways you could do this. One possibility is that you just glance down the items starting at the first question, think to yourself 'True' or 'False', make a decision and then move on to the second question, and so on. That's fine. The other possibility, however, is to take some time to consider each answer. Jot down a few notes in your notebook . . . weighing up the pros and cons for both true and false. I think you would get more out of doing it this second way, but it's up to you.

Box 2 Sleep Quiz

- True/False We need less sleep in later life.
- True/False I tried to sleep better as the night goes on.
- True/False I should try to make up for all our lost sleep on subsequent nights.
- True/False Waking a lot is usually a sign of emotional upset.
- True/False Sleep is important for our memory.
- True/False The more sleep we can get, the better we will feel the next day.
- True/False Being irritable during the day probably means our sleep quality is poor.
- True/False Adults sleep 7–8 hours at night.
- True/False There really is no such thing as 'deep sleep'.
- True/False Extreme tiredness may be an important sign of a sleep disorder.
- True/False Sleep problems usually pass away quite quickly.
- True/False People don't cope very well after a bad night's sleep.
- True/False Sleeping pills are addictive.
- True/False A nap should be avoided if at all possible.
- True/False Changes can trigger insomnia.
- True/False People seem to be able to do without sleep.
- True/False Depression causes insomnia.
- True/False It's better just giving up because I've tried it all before.

OK – now I will take you through my answers. Some of the statements were a bit tricky because it is not always a straightforward choice!

Quiz Answers

1. People Need Less Sleep in Later Life

The amount we sleep changes throughout our life. The newborn baby might sleep for more than 18 hours, waking only to be fed; most infants and young children sleep from the early evening through to morning, as well as sometimes having naps in the

daytime. ‘Deep’ sleep and ‘dreaming’ sleep are particularly plentiful in these early years because these types of sleep are associated with physical and mental development. At the opposite end of the age spectrum, older adults who are not using as much energy or discovering as much new information have less ‘deep’ sleep. Older adults, in fact, tend to sleep less in total than younger adults, and can have more broken sleep, especially in the second half of the night. It is important to recognize that some of our sleep problems, for example ‘lighter’ sleep as we get older, are just normal changes. Changes like this can sometimes be very hard to accept. In short, the answer to this first point is TRUE.

Now this first quiz question is probably an example of something you already knew. But let me pose an important challenge to you: have you really adjusted your *expectations* of how much sleep you need as you have grown older? Just because you know in your head that you may need less sleep doesn’t mean to say that you have accepted that change and are feeling OK about it.

Perhaps you have never thought of making any conscious decision about adjusting your sleep habits. But things do change. Not everyone still fits into their bridal gown or their wedding suit. Do you remember as a child, when you were gradually allowed to stay up a bit later . . . then later still? Those changes in bedtime pattern probably just reflected your sleep requirement at that age and stage of your life. This may be a good time to stop and think if adjustments might be appropriate again. You see, one major problem with insomnia is that we may overcompensate for our sleeplessness by spending longer in bed – to try to catch up on more sleep. The problem is we can then end up with more frustration, simply because we are in bed for too long, compared with our ability to sleep. You may know about this vicious circle already!

2. We Tend to Sleep Better as the Night Goes On

Don’t we just love to get into a deep sleep? It might be nice to think of the night’s journey in sleep as one big, deep valley with a flat bottom. That we gradually descend down the slopes from wakefulness into the fertile and expansive plain of deep sleep, and that, with the coming of the morning, we slowly rise up the other side to wakefulness once more. But it’s not like that at all. Throughout the night we have different types of sleep. Some of it is ‘lighter’, some ‘deeper’, and some is REM sleep when we do most of our dreaming. We cycle through these stages each night. We have several sets of valleys and summits to negotiate on the night’s journey. Usually, our deepest sleep is during the first couple of hours of the night, and our lighter sleep is during the second half. So the answer here is undoubtedly FALSE.

But don’t take this as bad news! What it means is that nature has organized things in such a way that even if our sleep is short in duration, we get the biggest payback out of the early sleep episodes. These are the most restorative periods, and that is why you can sometimes wake quite refreshed after just a couple of hours of sleep. It is also why you don’t need to catch up on all your ‘lost’ sleep.

3. We Should Try to Make Up for all Our Lost Sleep on Subsequent Nights

This is one of the tricky ones . . . but I’ve just hinted at the answer!

You may remember that I explained about ‘sleep debt’? The idea being that during the day we build up sleep debt that is then repaid at night, allowing us to start ideally with a zero balance at the beginning of the next new day. There might seem to be a danger then for people with insomnia. Not sleeping well might mean that they don’t pay off sufficient debt and end up being in long-term arrears! But fortunately this is where the sleep-debt model actually breaks down. We do not need to repay sleep loss on an hour-for-hour basis. The best evidence we have suggests that we need to make up less than one-third of our lost hours. Furthermore, the sleep we get on recovery nights may be deeper and more restorative. I would say, therefore, that the answer to this question is FALSE. We should *not* try to make up for all our lost sleep on subsequent nights. Besides, there is another angle to this question. We should not assume that any time we spend awake in bed is time ‘lost’ to sleep. In fact, we may not need to sleep all through the time we spend in bed in order to get a satisfactory rest. The vicious circle that I mentioned in answering Question 1 reminds us that part of the problem with insomnia is that too much time might be spent in bed in the first place.

4. Dreaming a lot is Usually a Sign of Emotional Upset

We usually have about six spells of dreaming sleep during the night, although of course some people remember their dreams more than others. Dreams are a normal part of our sleep whether or not we remember them. The answer to this question is certainly FALSE – dreaming is not a sign of emotional upset. It is possible that we dream more when we have a lot on our minds, and there are people who have recurring dreams of a nightmarish quality. Such dreams may have some root in unpleasant experiences or unpleasant memories. In general terms, however, dreaming should be regarded as a healthy experience that is simply a reflection of REM sleep. People may also dream more than usual during withdrawal periods from sleeping pills, and also in the latter part of the night if they have consumed a significant amount of alcohol. These are both temporary factors influencing dreaming sleep.

5. Sleep is Important for Our Memory

Sleep is a time when a lot actually goes on. It is important to realize that sleep is not simply the absence of wakefulness; it is a time when a great deal of different kinds of activity occurs. This activity takes place both in our minds and in our bodies. So although we switch off the lights when we go to bed, we are not switching ourselves off when we fall asleep.

Sleep is necessary for both physical and mental rest. Tired muscles and bodies need to rest in order for our energy sources to recover, and while we sleep our body chemistry works to rebuild itself for the next day. The harder our bodies work, the more we may find we need to sleep. The same is true for our minds. The brain can do with a break, too! But while we mostly stop taking in new information through our senses, our brains are really still on the job. Sleep gives the brain the space and time to sort out information about things that have happened during the day. What we have experienced and learned is processed even though we are not usually conscious of it, and memories are being stored. All this is part of the mystery of the sleep

process – we simply can't do without it. There is no doubt that sleep is important for our memory; so the answer to this statement is TRUE.

6. The More Sleep We Can Get the Better We Will Feel the Next Day

Let me say straight off that the answer to this statement is FALSE. There is no direct relationship between quantity of sleep and well-being. The total amount of sleep that people in the general population obtain follows what is known as a normal distribution. In other words, it is just as normal to be a short sleeper (someone with a short sleep requirement) as it is to be a long sleeper (a person with a longer sleep requirement). The long sleepers don't feel any better than the short sleepers.

Although it may be possible for people who are good sleepers to sleep more than they actually need, there is little evidence that they benefit in the daytime from doing so, except that it is nice to have that choice! There are even some disadvantages associated with oversleeping, because doing so may strengthen what we call *sleep inertia*. This is the experience we have of emerging from sleep into daytime waking with a feeling of struggling to get going. I am sure you have been there. Oversleeping can contribute to sleep inertia rather than feeling refreshed, so the idea that the more you sleep the better you will feel is simply not true. The most important thing is to establish our personal sleep requirement, and to try to obtain that on a regular basis from night to night.

7. Feeling Irritable During the Day Probably Means Our Sleep Quality is Poor

It is undoubtedly true that irritability can be associated with insomnia, but again this is one of those tricky ones, because there are, after all, many other reasons why we may become irritable during the day.

This is an example of what we call *attribution* or *beliefs*. We know that people who have insomnia will be likely to attribute experiences that they have in the daytime to having slept poorly, but that does not necessarily mean that the insomnia has actually caused these events. I think on balance I would answer this one as FALSE, on the basis that irritability could equally well be associated with frustration at work, difficulty solving a problem, relationship difficulties, and so on. That is not, however, to deny the important relationship between night-time sleep and daytime mood.

I must confess I put this item in the quiz quite deliberately to help you to think through the whole issue of attribution. Think back to the statement 'What we know and what we feel are not necessarily the same thing.' It is important to evaluate your strength of feeling that irritability (or any other daytime symptom, such as tiredness) results directly from your insomnia. More than that, it is important to evaluate your belief in that particular association, against the possibility of other explanations. This process of evaluation will help you to make more accurate attributions. Then you will be in the strongest position to deal more effectively with the most likely causes of how you are feeling. So, for example, you may find that there are stressors at work that need some attention, as well as improvements that need to be made to your sleep pattern.

Going back to the quiz, it would be fairer to say that feeling irritable is possibly related to poor sleep, but that other possible explanations should also be considered.

8. Most Adults Sleep 7–8 Hours at Night

How much sleep does a person need? This is probably the most commonly asked question I come across. Unfortunately, there is not just one answer. The amount of sleep we need varies depending on our age, and on what we are doing in our lives. It also varies from person to person. It is important for people to discover their own personal sleep needs, at a particular point in time. That is one of the reasons you are using a Sleep Diary right now.

However, it is in fact TRUE that the average adult sleep is around 7 to 8 hours. If we take all adults from, say, 20 to 80 years and work out the average amount of sleep they have, it will be in the 7- to 8-hour range. We might then say that most adults sleep about this amount because the greatest proportion of people lie close to the average. The problem with averages, though, is that not everyone is the same. Some people can survive on as little as 4 hours of sleep a night, while other people seem to need up to 10 hours. These people are different from the average, different from each other, but not necessarily abnormal.

9. There is Really No Such Thing as ‘Deep Sleep’

The term ‘deep sleep’ sounds very much like what the general public might say, rather than a scientific description. You might think, therefore, that there is no such thing as deep sleep. However, this is a term that is also used in the research literature on sleep and in the clinical literature on sleep disorders. Deep sleep refers to non-REM sleep Stages 3 and 4, which are characterized by slow-wave EEG patterns. That is, the EEG waves are of high amplitude and low frequency, and are synchronized. These are sometimes called delta waves (see p. 8).

The answer to this question, therefore, is FALSE. Deep sleep *does* exist and it is characteristic of our sleep, particularly during the first part of the night. In later life, older adults have much less slow-wave sleep, and so their non-REM sleep contains higher proportions of the lighter Stage 2 sleep. In this sense older adults do not sleep as deeply as younger adults.

10. Daytime Tiredness may be an Important Sign of a Sleep Disorder

I put this one in to help you consider the differences between tiredness and sleepiness. This is an important distinction to make. Tiredness is almost always present when people feel sleepy, but sleepiness is not always present when people feel tired. I think it is TRUE to say that daytime tiredness may be an important sign of a sleep disorder, but it is important to consider the extent to which you would also be at risk of falling asleep either when given the opportunity, or involuntarily.

There are a number of disorders that involve symptoms of excessive sleepiness, such as narcolepsy and sleep-related breathing disorder. Such disorders will not

respond to CBT for insomnia, so it is important to identify them. One way to do this is to consider the tiredness–sleepiness dimension. People with insomnia commonly report feeling tired but do not report feeling that they are going to fall asleep. Quite the opposite: they tend to have difficulty getting to sleep . . . even during the day!

11. Sleep Problems Usually Pass Away Quite Quickly

Of course, occasional sleep disturbance is very common. Everyone experiences difficulty getting to sleep or staying asleep at some time in their lives. It is TRUE that these problems usually sort themselves out and end up being short-lived. However, about 10 per cent of adults, that is 1 in 10 people, experience persistent sleep problems, and this can be as high as 1 in 5 (20 per cent) in people over 65 years of age. There are probably even more people out there who suffer with insomnia but who do not seek help for it.

12. Most People Don't Cope Very Well After a Bad Night's Sleep

Many people with sleep problems worry about them. They may worry about how they will cope, about having to take sleeping pills, about whether the insomnia is causing them serious harm, and about whether it will ever go away. Although insomnia is distressing, and can be depressing, people often come to incorrect conclusions about their ability to sleep and the effects that sleeplessness will have.

Thoughts that run through our heads can make the problem much worse. Thinking 'I'm never going to get to sleep tonight' or 'I'll be hopeless at all the things I've got to do tomorrow' is *exaggerated*, and is likely to get us more upset and make sleep even harder to come. Most people actually do manage to cope during the daytime even after a bad night's sleep and you always get at least some sleep. In fact, only a proportion of people with insomnia feel tired after a bad night. You see the body is designed to handle a certain amount of sleeplessness. It can be reassuring to know that even after a lot of lost sleep, it is not necessary to make it all up on other nights.

So, I have put this one down as FALSE. Of course, insomnia can cause problems with concentration, and we can feel tired, edgy and irritable. But we must remember to try to keep our thinking about sleep in proportion. After all, good sleepers get bad-tempered, too. The less you focus your concerns on sleep, the more you will succeed with sleep.

13. Sleeping Pills are Addictive

Although it may seem surprising, sleeping pills can affect our sleep in a negative way. The pills may help at first, but they often end up giving us problems rather than solving them, once our bodies become more and more used to them. Another thing is that many types of sleeping pills actually change the type of sleep we get, and they are not as good for us as a natural sleep. Because stopping some sleeping pills too quickly can cause severe insomnia, some people find that it is difficult to stop taking them. It is certainly TRUE, then, that some sleeping pills are dependency-forming, both physically and psychologically. You should bear in mind that any type of

medication can become a behavioral habit just because we get used to taking them.

14. Taking a Nap Should be Avoided if at all Possible

If you absolutely have to take a nap because you are sleepy, then you should not try to prevent yourself from having that sleep. Resisting sleepiness can be dangerous. Then again, however, we might be wondering why you feel so sleepy, if you have insomnia and not any other type of sleep problem. So this also is a difficult question to answer.

If we take it from the perspective that you have insomnia then I would say the answer to the question is TRUE. You should avoid taking a nap if it is at all possible, because napping during the day will reduce your homeostatic drive for sleep at night. A nap of more than around 15 minutes is likely to have some consequence for your ability to sleep at night, whereas short naps have a lesser impact, because they do not reduce the night-time sleep drive to the same extent.

15. Life Changes can Trigger Insomnia

Everyone experiences stresses and strains in their day-to-day lives at home and at work, and there are times when these stresses can be severe. Such times can produce short-term sleep disturbance. However, temporary sleep problems do not always disappear even when problems have passed. This usually happens because our sleep schedule has been upset and poor sleep habits develop, or because we have learned to worry about not sleeping.

Changes in our lives, even positive changes like moving to a new house or switching to a better job, can also affect our sleep pattern. Any change is potentially stressful because we have to adapt to it. Some sleep difficulties are initially caused by health problems. Pain, discomfort or illness may upset us both physically and emotionally, and sleep problems may result. Similarly, psychological disorders like depression or anxiety can be associated with sleeplessness, but the insomnia can keep going even when we feel mentally stronger again. My conclusion, then, is that this is TRUE; life changes can trigger insomnia.

Did you identify in your sleep history any life events that might at first have triggered your sleep problem? Take a moment to look back at your notebook and see what you wrote down. Jot down anything else that comes to mind now.

16. Some People Seem to be Able to do without Sleep

I do not know of anyone who has ever been able to do without sleep, so this statement must be FALSE. In a manner of speaking, it may seem that some people hardly need any sleep, but the reality is that everyone does need sleep. Most people can manage to stay up for a night, or maybe two nights, and in that sense go without sleep, but that is a very short-term state of affairs and is not advisable. If we produce a situation where we are objectively sleepy in the daytime, then there is definitely an increased risk of accidents.

17. Depression Causes Insomnia

Sleep disturbance is a common symptom of a wide range of psychological and other mental disorders, including depression. Indeed, it is unusual to find someone with depression who does not have sleep disturbance. Insomnia, therefore, is so commonly associated with depression that on balance I am going to give the answer TRUE to this one.

However, we know from quite a large number of studies now that insomnia symptoms often occur before other depressive symptoms, and that insomnia is a risk factor for the development of depression. Would it be equally accurate, then, to say that insomnia causes depression? Well, in truth we do not have sufficient evidence to figure out the relationship between the two at this stage, but perhaps how we treat insomnia might prevent or delay depression arising in some individuals. Also we know that treating depression may not necessarily get rid of insomnia symptoms. So even if you are depressed, it would be useful for you to work through this CBT program for insomnia alongside getting treatment for your depression.

18. I'd be Better Just Giving Up Because I've Tried it all Before

To be honest, I put this statement in deliberately to be provocative! The answer, of course, is FALSE. You would be better reading on and learning more about how to overcome your insomnia.

Well that's the quiz and those were my answers! How did you do?

Using Information to Change Your Mind

The point to it all is that you can use information to 'change your mind'. I want you to spend this next week using the information you have learned, not just in this chapter but throughout the book so far, to challenge your thoughts, beliefs and emotions, and to put insomnia in perspective. You have been feeling out of control where sleep is concerned and now it is time to put you back in the driving seat.

How you view your insomnia is so very important. People often tell me that insomnia has become the biggest thing in their lives. You know that I think insomnia is a 'big thing' too, otherwise I wouldn't have written this book and spent so much time researching insomnia. But . . . you absolutely *must* get out of any self-defeating perspective that leaves you feeling powerless and in its grip. You have to step firmly *towards* problem-solving and move decisively *away* from a position of defeat or panic. You need to recognize that although insomnia frustrates and infuriates you, your upset and anger about it are unlikely to drive it away! Instead, we are going to see insomnia as a problem to be solved, a major problem perhaps, but nevertheless one that can be solved.

Evaluating Your Thoughts

Question: How do you make a start in overcoming insomnia? Answer: By not letting it get the better of you . . . and how do you do that?

By thinking through your thoughts and concerns about sleep and sleeplessness *clearly* and *accurately*.

A number of the statements so far have referred to concerns that people have about their insomnia, and the need to *evaluate* how accurate these thoughts are. Have a look at Table 7 on p. 100. You will see that I have given some examples of faulty thinking and how it might be corrected. The process is:

1. to record the thought as carefully as you can
2. to consider how thinking this thought makes you feel, and to write that down
3. to reconsider the thought critically – that is, to evaluate it and to write down a new and more accurate version of the thought
4. to consider how thinking this *new* way makes you feel.

Do you get the idea? I want you to start *evaluating* your own thoughts and feelings about sleep and insomnia, as accurately as possible. I have provided a blank copy of this form for you (Table 8 on p. 101). You should make some photocopies of this and keep them with your notebook. Use these blank forms to write down the main concerns you have right now and to consider if there is another way of putting them that would be more helpful to you. Remember you can use factual information to influence what you think *and* how you feel. Follow the format I have shown you in Table 7 by putting your thoughts inside quotation marks (‘. . .’) so that you realize that this is the way you are thinking. It takes a bit of getting used to using this approach, but in my experience people with insomnia really benefit from first identifying their typical thoughts, and then evaluating them.

A lot of worry and concern over sleeplessness is based on information and beliefs that are not accurate. Negative or *faulty* beliefs are faulty because they are simply beliefs – that is, they are not necessarily facts. It’s your responsibility to check them out – after all, they are your attributions and your beliefs – they belong to you! The good news is that faulty beliefs can be corrected, and attributions can be made more accurate.

Changing them can affect your attitudes to sleep and how you feel. A different mind-set really can help promote sleep!

You will have realized by now that CBT for insomnia involves quite a few paper-and-pencil exercises – your Sleep Diary, your notebook, a quiz . . . now thought evaluation forms! I need to tell you there will be more before we are done! Why is this? Is it all really necessary?

Believe me, you will be tempted to skip some of this paper-and-pencil stuff, but please don’t. It is important because a person’s whole approach to a sleep problem is based on the information they have, how they evaluate that information, and what they then do about it. I don’t think you are any different from this general rule. Accurate information about sleep and accurate thinking about sleep and its consequences will adjust your thoughts and feelings about your sleep . . . and will begin to modify your sleep pattern.

Dr Charles Morin has written extensively about the relationship between dysfunctional beliefs and attitudes about sleep, and sleeping itself. His research demonstrates that dysfunctional thinking (as in Table 7) is common in insomnia, but that changing to a more accurate thinking style is associated with significant improvement in sleep. So I urge you to keep going with your record-keeping in the Sleep Diary and to work hard at these thought-evaluation exercises. I would go so far

Table 7 Evaluating your thoughts and concerns about insomnia – some examples

My thoughts about sleep and sleeplessness	How this makes me feel	A more accurate version of my thoughts would be	How this version makes me feel
<i>'It seems as if I am awake half the night and everyone else is sleeping.'</i>	Anxious, annoyed, lonely, jealous	<i>'I probably sleep around 6 hours and have 2 hours awake in bed; that's 75% (three-quarters) not 50%. Also if there are 1 million people living in this city and half of them are adults, maybe 50,000 are having serious problems. Everyone else is not sleeping!'</i>	Reassured, more optimistic, less angry
<i>'I'm never going to get to sleep tonight.'</i>	Demoralized, out of control	<i>'Almost certainly I will fall asleep. I always get some sleep. The average in my diary was 6 hours and I never got less than 3–4 hours.'</i>	More accepting, relieved, more relaxed
<i>'I'm so tired I just can't concentrate. It's because I slept so badly last night.'</i>	Hopeless, preoccupied with sleep, irritable	<i>'My concentration is not just down to my sleep. I've slept worse than I did last night and felt better during the day. Maybe I'm bored, or doing too much at once, or ...'</i>	More in control, able to focus

as to suggest that you keep a fresh copy of the thought-evaluation form in your pocket through the day so that you can write down things as they occur to you. Work away at becoming a more accurate thinker. It will be time well invested in improving your sleep.

Sleep Hygiene and Relaxation (Program Week 3)

Introduction

Please remember that I have designed your program to build up over the weeks. These new suggestions are not designed to replace what has gone before! I don't want you to substitute good practices that you have established, because you will get most benefit if you continue to follow previous advice as well as adding in new information each week. So far, then, you should be in the regular practice of evaluating your thoughts and feelings about sleep.

What is *sleep hygiene*? I agree it is a strange term, and not one I particularly like. However, it is increasingly being used, so we are kind of stuck with it now. On the positive side it conveys the idea of the 'sleep basics': what anyone could do to tidy up their sleep preparation, if you like. Sleep hygiene refers to things about your lifestyle and your preparation for bed that might be changed to improve your sleep pattern. Sometimes there may be a simple solution to a sleep problem, such as stopping drinking excessive amounts of coffee. However, for most people it is a case of making the most of all of the good sleep-hygiene practices to make sure that you are better prepared for sleep.

Sleep hygiene can be split into two parts. First, how your lifestyle affects your sleep, and second, how you can plan a bedtime routine that supports good sleep. We will take these two areas in turn, and then go on to consider the very important matter of relaxation.

Aim

The purpose of this chapter is to introduce steps towards *developing a healthy and natural sleep pattern without having to use medication, and to learn how to relax.*

Good Lifestyle, Good Sleep?

The main lifestyle factors known to have an effect on sleep are caffeine, nicotine, alcohol, diet, and exercise. I would like to give you some recommendations about each of these.

Caffeine

Caffeine is a type of drug called a stimulant. This means that it perks you up by having a stimulating effect on your nervous system. Too much caffeine is very good at keeping you awake.

Most people know that caffeine is found in coffee and tea, but many other products also contain caffeine. For example, cocoa, chocolate bars, soft drinks like sodas, and some medicines you can buy at the store for headaches and to help you lose weight. Because caffeine is found in so many different products, I have a suggestion. Have a rummage in your kitchen cupboards, in your refrigerator and in your medicine cabinet. See how many products you can find that have caffeine listed on them as an ingredient. You can use Table 9 to keep a note as you go along. I suggest that you make a special point of checking the labels on things you might eat or drink in the evening and before bedtime. Caffeine's effects can last for many hours and it is a good idea not to have any caffeine for 4 to 6 hours before bedtime.

If you would like to cut down on caffeine, or cut out caffeine altogether, you can try switching to caffeine-free drinks such as decaffeinated tea or coffee, herbal tea or caffeine-free cola. Please note that some people who are used to drinking caffeinated beverages on a daily basis experience headaches for the first few days of not drinking them. This is like a withdrawal effect, but it disappears quickly after a couple of days.

Table 9 Caffeine products that you use

Products in the kitchen containing caffeine	Products elsewhere in the house/at work/ when dining out containing caffeine
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Nicotine

Nicotine, which is found in cigarettes and other tobacco products, is also a stimulant drug and has similar effects to caffeine on sleep. Although many people say that they find that smoking is relaxing, the overall effect of nicotine on the body's central nervous system is that of stimulation. What this means is that nicotine will make it harder to fall asleep and harder to stay asleep.

If you smoke, I recommend that you try and cut down in the evening before you go to bed, and that you try not to smoke if you wake up in the middle of the night. You need to consider the possibility that you wake up with a craving for a cigarette and that this has become part of your smoking habit. I know all this is easier said than done, but it could be important.

Alcohol

Alcohol, unlike caffeine and nicotine, is a depressant drug. Normally, depressants should help us sleep, but it has been found that even a moderate amount of alcohol in the evening can actually have a disruptive effect on sleep.

Alcohol may help you to fall into a deep sleep at the beginning of the night. In this sense it is an effective hypnotic drug. However, as the alcohol gets absorbed into your body, mild withdrawal symptoms occur that may be sufficient to wake you up or put you into a lighter form of sleep. Alcohol can also cause you to become dehydrated so you may wake up thirsty in the middle of the night, and need to go to the toilet more often than usual. For people with persistent insomnia, the use of alcohol in an effort to promote sleep is particularly unwise because it can encourage dependence. I recommend that you avoid drinking alcohol from 4 hours before bedtime.

Diet

Hunger can cause wakefulness. That is why a light snack a little before bedtime can help us sleep. On the other hand, going to bed too full can also cause wakefulness. Our bodies are busy digesting the food, and this interferes with sleep.

Yes, some of those old beliefs may be true – milk and other dairy products may help to promote sleep . . . if only a very little. Although having a warm milky drink before bed may help you fall off to sleep, it is doubtful whether or not milk helps improve the quality of a person's sleep. I guess what we can say with some certainty in this regard, though, is that it is preferable to caffeinated coffee or tea.

It is probably wise also to avoid snacking if you wake up in the night, as your body may come to expect food at this time. If you do snack at night then you run the risk of continuing to wake up in the middle of the night to satisfy your hunger. A glass of water at the side of the bed is a good idea because a few sips help freshen the mouth and take the edge off your thirst, without causing you to have to run to the bathroom.

Weight changes can also have some effect upon sleep. Too much weight loss over a short time period may lead to short, broken-up sleep. If you are trying to lose weight, I suggest that you aim to lose no more than a pound or two per week, and that you stick to your program of weight reduction until you achieve your target weight. Heavier people are more likely to snore, which can disrupt sleep both for themselves and others . . . and losing weight can reduce snoring. In general healthy people are better sleepers, so managing your diet is a good idea.

Exercise

People who are physically fit have a better quality of sleep, so a good way to promote sleep is to get fit by exercising three times a week for 20–30 minutes. The type of exercise you do really depends on what kind of activities you enjoy. It is recommended, however, that in order to get fit and stay fit, you should take up exercise that gets your heart pumping. Walking, swimming, cycling, skating, football, squash, badminton, and aerobics are just a few of the many activities that do

this. If you are unsure about exercising, please talk to your doctor before starting an exercise program.

Although being fit is beneficial to sleep, I need to warn you against strenuous exercise before bedtime. Exercise taken late on ‘wakes up’ the nervous system and can lead to problems falling asleep and problems staying asleep. Even exercise in the evening can have these unwanted effects. So the idea of going out at night to exhaust yourself and then falling into bed is not a good one. If you want to help your night-time sleep, I would say that the best time to take your exercise is in the late afternoon or in the early part of the evening.

Let’s have a pause for thought at this point. Do you think that your lifestyle could be improved to help you sleep? Write down any decisions you have made about each of these lifestyle areas in Table 10. You can keep coming back to your decisions to see if you have carried them through.

Table 10 Sleep hygiene changes in my lifestyle

Caffeine

Nicotine

Alcohol

Diet

Exercise

Pre-Bedtime Routine

It is time now to consider the second part of sleep hygiene – the bedroom itself, and your preparation for going to bed. Noise levels, room temperature, the quality of the air in the bedroom, lighting levels, and the comfort of the mattress and pillows can all influence our sleep.

Noise

You will not be surprised to learn that noise is a common enemy of sleep! Unexpected and sudden noises, if loud enough, will wake most people either from the gentle reverie of the just-about-asleep stage, or even from deep sleep. The cry of a baby, the sound of a telephone ringing, a car horn and, of course, an alarm clock are all examples of these kinds of sounds. However, we know that people can get used to

noises after a while, although some folks may be better at this than others. For example, people who live in houses close to railway tracks seem to adapt to the sounds of passing trains. Also, most people get used to noise that is continuous, such as a ticking clock, or even a partner's snoring! Nevertheless, even if people do not actually wake up in response to noises, their sleep may be affected as a result of brief transitions from deeper to lighter forms of sleep.

Well, what about you? Try to figure out any noises in your home environment that may be interfering with your sleep, and do what you can about them. Sleeping with earplugs may or may not be the answer for you. If you are troubled by outside noises, wearing earplugs may just cause you to listen in to your own inner sounds, like your breathing. But you could experiment and find out. Probably you will find that distraction techniques, like relaxation exercises, are more helpful rather than getting too preoccupied with something you can't easily change.

Room Temperature

Extreme temperatures at either end of the range can affect our sleep. A room that is too hot (more than 24°C or 75°F) can cause us to have restless body movements during sleep, more night-time wakings, and less dreaming sleep. On the other hand, a room that is too cold (less than 12°C or 54°F) can make it difficult to get to sleep and can cause more unpleasant and emotional dreams. I would suggest that the ideal room temperature to help promote sleep is likely to be around 18°C (64°F). Why don't you try it out and see? Buy a thermometer and experiment with the climate in your bedroom.

Body Temperature

People sometimes like to take a hot bath because they find it helps them to relax. You might think this must be a good thing. However, it may or may not help you to get to sleep. We know, for example, that poor sleepers often report feeling hotter than good sleepers. It is not a good idea to be too hot when you go to bed, so I recommend that you can best prepare your body for bed by taking your bath around one hour before bedtime, rather than immediately before retiring. Make it part of your pre-bed routine (at least some nights).

Air Quality

A stuffy room is likely to cause an uncomfortable sleep, while fresh air will promote sleep. Why don't you try opening a window for a bit before going to bed, or adjusting the air-conditioning to give you fresh clean air? The circulation of good-quality air is going to be helpful. Of course you have to bear the seasons in mind. You may not want to leave a window open all night, especially in the winter. See what you can do to adjust that blend of temperature and air control so that it is right for you.

Lighting

Do you remember when I explained how natural light is a major controlling factor in the sleep–wake (circadian) rhythm? We are all familiar with a parent saying that their child can’t get to sleep because it is still light outside, or the child waking up earlier in the summer because it is getting light earlier. Natural light, of course, normally penetrates into the bedroom, too – through the window! Don’t miss the obvious. Your bedroom at home should not be too bright. A combination of summer nights, or even strong street lighting, and thin curtains should be avoided. I would go as far as to say that your bedroom should be almost completely dark once you have switched off the light. Not totally dark, because that may cause anxiety as well as being rather unnatural. The simplest solution is to cover windows with thick curtains, blinds, or even a blanket during your sleep period. Some people find they can sleep well with a sleep mask on, although not everybody will find these comfortable. If you prefer to have a bit of light, try to keep it very low level, like a small lamp in the hallway with the door very slightly ajar, or a plug-in nightlight of minimal wattage.

Mattress and Pillows

There are a lot of personal preferences when it comes to pillows and mattresses, so it is hard for me to give advice that will suit everyone. One thing that does strike me, though, is that we know that people with insomnia sometimes sleep better in an unfamiliar environment. As mentioned earlier, this may be because they don’t expect to sleep, so they don’t worry about it quite so much. It may be because the triggers to poor sleep – all the associations with nights spent tossing and turning – are left back at home. But another simple possibility is that other beds suit their sleep needs better than their bed at home.

Could any of this apply to you? For example, beds in hotels are often larger and have firmer mattresses than domestic beds. Remember, too, that beds and mattresses of different qualities have differing life spans. A bed can be one of those things where what you pay for is what you get. You can experiment a bit, though. For example, if you have a soft mattress you can make it firmer by placing a board underneath it. But if you can feel the springs, it is certainly time to buy a new one. You may also wish to try switching beds if there are others in your home, to see if you can find the level of comfort you need before purchasing. And salespeople in stores can actually be quite helpful.

There is no real standard for pillows. What people prefer and find most suitable depends a lot on personal taste. But don’t make assumptions – be prepared to experiment again. Remember that you don’t sleep well – so why are you convinced that you ‘need’ two pillows? Maybe no pillows would work! Also make sure that you don’t have any allergies to the pillow contents, and keep your pillows and pillowslips clean by laundering them regularly. Same goes for your bed linen/duvet. It is also worth considering the amount of bed-covering you need for comfort, and the weight of covering that best suits you.

Just as you did with lifestyle factors, I would like you now to use Table 11 to note down things that you think you need to consider about your bedroom and your sleep.

Table 11 Sleep hygiene changes in my bedroom environment

Noise

Temperature

Air quality

Lighting

Mattress/pillows

So here is where we have got to so far with this thing called sleep hygiene. Figure 11 will help you to get the bigger picture of lifestyle and bedroom factors that might affect your sleep.

Bedtime Wind-Down

It is a completely ridiculous idea to expect that you will just fall into bed and fall asleep because you happen to believe it is 'bedtime'. OK, you are going to say that some people can! Well maybe so. But on the other hand, *you* have got a sleep problem and they don't. And then again, maybe it is more common for people who sleep well to be good at winding down before bedtime.

I am going to suggest to you that you should develop a *wind-down* routine starting at least 60–90 minutes before bed so that you can start relaxing and preparing for sleep. Your routine should include things like slowing down your work/activity and then stopping it, and having some time to do a number of other things before getting into the immediate pre-bed activities of locking up, brushing your teeth, putting your pyjamas on, setting your alarm clock, and so on. Your routine should be on the one hand carefully planned, but on the other hand should not be rigid or inflexible. I have provided you with a planner (Figure 12) that you will need to personalize to suit your own times and activities.

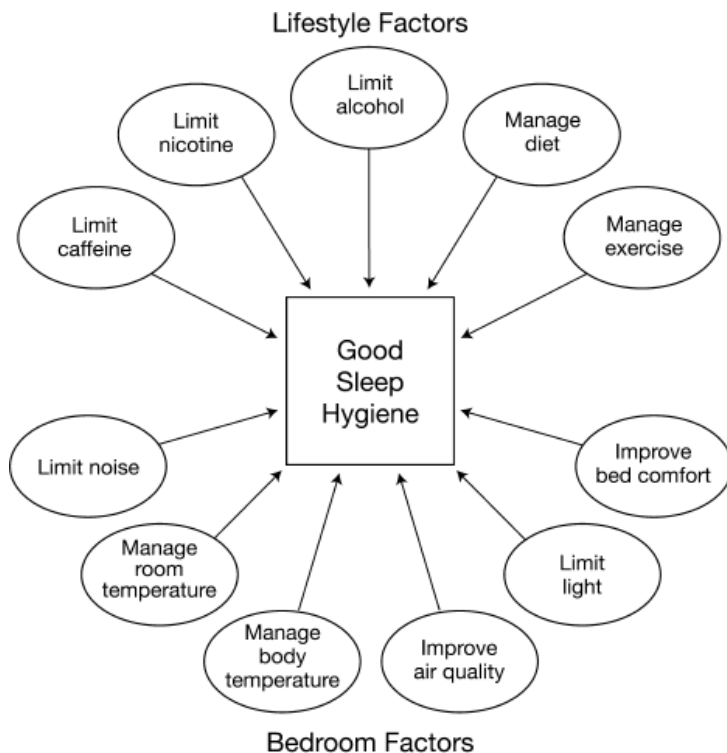


Figure 11 Sleep hygiene factors to improve your sleep pattern

Just a few tips, then it is up to you to consider the detail. It is a good idea to sit down an hour or so before bedtime with a decaffeinated drink and a light snack, perhaps after a warm bath. You could read or watch TV or listen to some relaxing music, or have some pleasant conversation, or indeed a combination of all these things. The important thing is that this period before retiring to bed should help you start unwinding.

<i>Approximate evening time</i>	<i>Planned schedule</i>
7:45–8:30	Complete work/household activities of primary importance
8:30–10:00	Complete other activities
10:00–11:15	Work/activity completed Relaxation time (reading, TV, relaxation exercises, etc.)
11:15	Pre-bed sequence (lock up, change, wash.)
11:30	Retire to bed Practice relaxation

Figure 12 The bedtime wind-down

Remember that for many people this may be the one period of the day when they have some time for themselves. If this is the case for you, then you can make this time special by doing some things that you like, but with the purpose of relaxing and getting ready to sleep.

Learning to Relax

How often have you thought ‘If only I could relax, I would be able to sleep’? Well, there has to be truth in that. A relaxed state is certainly a prerequisite for sleep. But can you really learn to relax? I think you can.

I want you to be able to get nice and relaxed in preparation for falling asleep. More than that, in fact, I want you to become a more relaxed person! Fortunately, learning to relax is a general skill, one that can help you in a number of circumstances to take a more relaxed and less anxious approach. Practising a more relaxed approach in the day is helpful in itself, but it is also helpful with both technique and attitude at night. So how do you relax?

The grid in Box 3 shows you that there are really two types of *relaxation*. There is the relaxation that we get from *active* pursuits: ‘high energy’ relaxation, if you like, where we burn up physical and mental stress. Then there is more *passive* relaxation, which is like ‘letting go’ rather than burning up. I have given you an example of each

combination of relaxation approaches in Box 3. I suggest that to be a good all-rounder at relaxing you might want to pick up on something that suits you in each of the four quadrants. Easier said than done, I know, but worth a thought or two nonetheless.

Box 3 Different types of relaxation

Wanting to try the gym
Doing puzzles

Of course, there are things that are kind of in-between (more or less active, more or less passive), but hopefully you get my point. We all need to have more than one tool in the toolbox. Why don't you get that notebook out and try brainstorming as many examples as you can? Get someone to help if you like. Then hopefully you will be spoiled for choice in the things that you might try. If you don't come up with many options, or if you don't fancy any of them, then perhaps you don't like relaxing! That would be another challenge.

In my experience, people with insomnia often have difficulty with the *passive* approach to relaxation, the letting-go bit. Did you struggle for ideas there? It's so important with sleep that we learn to let it happen and not try to force it. I've decided, therefore, that I should try to give you a way of learning how to relax by letting go, using a technique that I use with my patients in my insomnia CBT clinic. The research evidence is that all relaxation methods have a similar effect, be they autogenic training, meditation, self-hypnosis, or muscular relaxation.

The technique I use is called *progressive relaxation training* and it includes components from other relaxation procedures. Progressive relaxation training includes the tensing and relaxing of the main muscle groups, which lead to decreases in muscle activity, blood pressure, and heart rate. It also includes help with breathing control and imagery (picturing) of relaxation responses.

Here is the text of what I say to my patients when I am going through relaxation training with them. Giving you this is the easiest way I can think of to help you learn the technique. One suggestion is that you read the text out slowly and record it (once you are familiar with it). That would give you a tape that you could listen to, to guide your practice. If you do it properly the exercises should take 12–15 minutes.

These exercises are designed to help you relax. Relaxation is a skill which you can learn. It is just like any other skill, so don't be surprised if you find it takes practice, because that is how we learn skills. So do practice. Practice a couple of times a day, especially as you start to learn.

It is best to practice at a time when you know you won't be disturbed. The exercises will last between 12 and 15 minutes, so you will need at least that length of time set aside. When you do your relaxation exercises in your bed you will be able to listen to the tape there, too. But after a while you will have learned what to do and you will be able to follow the exercises in your own mind.

Settle yourself down. Lie down with your hands and arms by your sides; have your eyes closed. That's good.

We will start by just thinking about your breathing. Your breathing can help you relax; the more deep and relaxed it is, the better you will feel and the more in control you will feel. So begin by taking some slow regular breaths. Do that now.

Breathe in fully, fill up your lungs fully; breathe in, hold your breath for a few seconds now, and let go, breathe out ... Do that again, another deep breath, filling your lungs fully when you breathe in, hold it ... and relax, breathe out. Continue in your own time, noticing that each time you breathe in the muscles in your chest tighten up, and as you breathe out there is a sense of letting go. You can think the word 'relax' each time you breathe out. This will remind you that breathing out helps you relax. It will also help you use this word to tell yourself to relax whenever you need to. You will find that your body will begin to respond. Breathing slowly, comfortably, regularly, and deeply; thinking the word 'relax' every time you breathe out; enjoying just lying still and having these moments to relax, concentrating on the exercises.

Now I'd like you to turn your attention to your arms and hands. I'd like you to create some tension in your hands and arms by pressing your fingers into the palms of your hands and making fists. Do that with both hands now. Feel the tension in your hands, feel the tension in your fingers and your wrists, feel the tension in your forearms. Notice what it is like. Keep it going ... and now relax. Let those hands flop. Let them do whatever they want to do; just let them relax. Breathing slowly and deeply, you will find that your fingers will just straighten out and flop, and your hands and arms will feel more relaxed. Allow them to sink into the bed; just allow your arms to be heavy. Breathing slowly and deeply, thinking the word 'relax' each time you breathe out, and finding that your hands and arms just relax more and more and more. Your arms and your hands are so heavy and rested. It's almost as if you couldn't be bothered moving them. Just because you have let go of the energy and tension that was in the muscles there. Breathing slowly and deeply, both your hands, both your arms, heavy and rested. Let go of the energy and tension that was in the muscles there, breathing slowly and deeply. Both your hands, both your arms, heavy and rested and relaxed.

I'd like you to turn your attention now to your neck and shoulders. Again we're going to get your neck and shoulders into a state of relaxation following some tension we're going to introduce. I'd like you to do that by pulling your shoulders up towards your ears. Now, do that; pull your shoulders up towards your ears. Feel the tension across the back of your neck, across the top of your back and in your shoulders. Feel the tension, keep it going not so much that it's sore, but keep it constant. Feel it, and now let go ... relax; go back to breathing slowly and deeply. Let that tension drain away, let it go. Breathe deeply, and as you do so, notice that the tension, almost like a stream, drains away from your neck, across your shoulders, down the upper part of your arms, down the lower part of your arms and out through your fingertips. Draining out and leaving a sense of warmth and relaxation deep in your muscles. Breathing slowly and deeply and allowing that to take place. Just let the tension go. If it doesn't seem to go, don't force it, it will go itself. Be confident about that. Just breathe slowly and deeply and allow yourself to be relaxed; remembering to think the word 'relax' each time you breathe out. Using that word 'relax' to focus on the sense of relaxation that you get, using the word 'relax' to remind you of the success you are having in relaxing your body.

I'd like you to concentrate now on your face, and on your jaw, and on your forehead. I'd like you to create some tension in these parts of your body by doing two things together at the same time. These things are to screw up your eyes really

tightly and bite your teeth together. Do these things together now. Bite your teeth together; feel the tension in your jaw. Screw up your eyes; feel the tension all around your eyes, in your forehead, in your cheeks, throughout your face, wherever there is tension. Now keep it going . . . and relax; breathing in through your nose and out through your mouth, slowly and deeply. Notice how your forehead smoothes out and then your eyelids and your cheeks. Allow your jaw to hang slightly open. Allow your whole head to feel heavy and to sink into the pillow; breathing slowly and deeply. Allow there to be a spread of relaxation across the surface of your face and into all those muscles in your face. Allow your eyelids to feel heavy and comfortable, your jaw and your whole head; breathing slowly and deeply, enjoying the relaxation which you feel in your body. Relax each time you breathe out. Relax just that little bit more each time you breathe out.

Concentrating now on your legs and feet, I want you to create some tension here by doing two things at the same time; and these things are to press the backs of your legs downwards and to pull your toes back towards your head. Do these things together now. Create the tension in your legs, press the backs of your legs downwards and pull your toes back towards your head. Feel the tension in your feet, in your toes, in your ankles, in the muscles in your legs. Feel what it is like. Don't overdo it; just notice what it is like . . . and relax. Breathing slowly and deeply once more; just allow your feet to flop any old way. Allow the muscles to give up their energy, give up their tension. Let it go, breathing slowly and deeply. Notice how your feet just want to flop to the side. Notice how your legs feel heavy as if you couldn't be bothered moving them. Heavy and comfortable and rested and relaxed. Just that little bit more relaxed each time you breathe out.

Be thinking about your whole body now; supported by the bed, sinking into it, but supported by it. You've let go the tension throughout your body. Your body feels rested, comfortable. Enjoy each deep breath you take. Just use these few moments now to think about any part of your body that doesn't feel quite so rested and allow the tension to go. It will go. Breathe slowly and deeply; thinking the word 'relax' each time you breathe out. Just let any remaining tension drain away; from your hands, your arms, your neck and your back. Heavy and rested, comfortable and relaxed. From your face and your eyes, from your forehead; letting the muscles give up their energy. Like a stream of relaxation flowing over your whole body. Let your legs and feet feel relaxed; sinking into the bed. Breathing slowly and deeply.

In a few moments, the exercises will be finished; but you can continue to relax. You may wish to repeat some of the exercises yourself and that is fine. You may wish to enjoy just continuing as you are. It's up to you, but continue to relax.

So, in concluding this section, let's try to bring this together. Your bedtime wind-down and pre-bed routine should encourage you to switch off from the day and to relax in preparation for sleep. The progressive relaxation training is there to help you relax even more. Here is what I mean, summarized in Box 4.

Box 4 A relaxation summary

Your Relaxation Program

Here are the steps you should follow for your relaxation program:

1. Wind down during the second half of the night.
2. Slow down or stop doing work/activity 90 minutes before bed.
3. Practice the relaxation routine while in bed:
 - Concentrate on your breathing
 - Tense and relax your muscles and breathe slowly and deeply
 - Take exercises slowly – do not overtense your muscles
4. Practise, practise, practise.

How Does the Good Sleeper Do It?

It must be a difficult thing to be a good sleeper, or so you would think! All this sleep hygiene, pre-bed routine, relaxation. Then there is evaluating your thoughts and beliefs and making accurate appraisals of them; the things we were learning about in the previous chapter. Then there is still more to come in the next few chapters – sleep scheduling, dealing with a racing mind, and so on!

How on earth do good sleepers do it? How do they fit all this in? But then there is a special secret. Good sleepers are good sleepers precisely because what they do is second nature to them. *They just **don't** really think about it.* Maybe they are not even the best at following good routines, maybe some of them have poor sleep hygiene practices! My point is that the good sleeper is different from you because whatever they do is not done deliberately or anxiously to influence sleep. They are not preoccupied about sleep, and so they sleep. And if they don't sleep so well . . . because they are not preoccupied about sleep, they tend not to get too concerned about it, so it sorts itself out.

In my experience good sleepers are not students of sleep. What they have is a set of behaviors, attitudes, and emotions about sleep that work. Their sleep-related behavior, the attitudes they have about sleep, and how they feel about sleep and about themselves as sleepers, simply supports sleep coming automatically and naturally. Nothing more, nothing less. 'So laid back as to be just about horizontal' is how the saying goes to describe someone who has a carefree approach. When it comes to sleep and the good sleeper, the saying, almost literally has a ring of truth about it.

I want to help you to overcome insomnia *and* to become a good sleeper. The bottom line is that the instructions and techniques I am giving you in this book provide only part of the recipe. You must learn to mix in the mind-set of the good sleeper. You are going to have to change to achieve that.

Saving on Effort?

I am going to draw a thin line for you in Figure 13. Here's the challenge. On the one side of the line I need you to be 100 per cent committed to putting into practice all the advice I can give you. On the other side, I want you to *stop* trying so hard! Motivation and commitment to the program are good; effort and preoccupation are bad.

I know better than most that you feel you are the victim of an under-recognized and poorly understood disorder that ruins enjoyment, not just of your sleep but of other parts of your life, too. I know that you want to beat it, and that you feel you have tried everything. I know that you want to try again . . . but I *also* know that a steady, calm, assured approach to doing things is the way to go.

COMMITMENT	UNPRODUCTIVE EFFORT
Being motivated	Trying too hard
Following advice	Getting more preoccupied
Sticking to the program	Forcing sleep
Returning to the program	Trying to win
Refusing to give up	Getting desperate

Figure 13 The thin line between commitment and unproductive effort

I need you to focus your determination on the left side of the line. Stay focused, follow the program, don't give up on yourself. If you forget or have a setback, pick it up again. If you cross the line, believe me you won't improve or stay improved for long. If you focus your efforts too much upon *trying* to sleep, *trying* to defeat insomnia, you may well feel up for the fight but you will have the level of arousal to go with the battle! Remember, the good sleeper is no conquering hero. You have to stop trying to drive insomnia from your bedroom door and to start permitting sleep to come to you in its own time. This is a theme that you will become familiar with as we carry on through the program. This is what I mean by relaxation.

Monitoring Your Sleep

Just before we move on to the next chapter and so the next session of the program, just a further reminder to use your Sleep Diary to assess your sleep pattern. I suggest that you keep that going throughout the CBT program. If you've done this so far, well done. If not, it doesn't mean you're a bad person! But I would encourage you to pick it up again and try to keep a note of your sleep pattern and sleep quality each morning when you get up. It will help you track your progress. Also remember to work on all the material in this chapter for a full week before moving on to the next section.

Scheduling a New Sleep Pattern (Program Week 4)

Introduction

Here we go, the new you coming up!

There is a lot to cover this week. What's more, most of the people with insomnia that I have seen find this part the most challenging of all. We are literally going to rebuild your sleep pattern. That means changes – so be prepared.

What I should also tell you, though, is that all of the senior figures in insomnia research agree that this sleep-scheduling component of CBT is the most important one. Incorporated into what I call *sleep scheduling* are procedures known in the insomnia world as *stimulus control* and *sleep restriction*.

Dr Richard Bootzin of the University of Arizona first developed stimulus-control procedures for insomnia more than 30 years ago, and Dr Art Spielman from the City College of New York added sleep-restriction guidelines during the 1980s. These are now the most effective components of CBT for insomnia. The American Academy of Sleep Medicine review groups that I have served on have recommended that sleep scheduling should be included at the heart of *every* CBT approach to insomnia.

You should not take this to mean that you might as well forget all of the advice in the other chapters. But it does mean that I want you to be *particularly* committed to following sleep scheduling through as best as you possibly can.

Aim

The purpose of this chapter is to *reshape your sleep so that it meets your individual needs and develops into a strong pattern that will last*.

Strengthening the Connection Between Bed and Sleep

Here is the starting point for sleep scheduling. What is the current connection between your bed and your sleep? That is probably a hard question, so let's start with an easier one. What is the connection between bed and sleep for the good sleeper? The good sleeper thinks of 'bed' and immediately thinks 'sleep'. Bed means sleep. You go to bed – you fall asleep. Bed is a place for . . . sleeping.

So back to you. What is the connection between bed and sleep in your experience? Well, I suppose it could be a number of things, but I could hazard a few guesses. You

think of ‘bed’ and you think ‘groan’ or ‘maybe tonight I will get some sleep.’ You might even have a kind of phobia about going to bed. Bed means for you lying awake tossing and turning. Thinking about going to bed makes you anxious. Bed means . . . a long shift till morning comes. You go to bed – you lie awake, you try to fill in the time somehow. Bed is a place . . . for sleeping, yes . . . except you don’t!

The simple point is that sleep will come more quickly and it will be easier for you to remain asleep if your mind and your body can make a *sleep response* to an important *cue*: your bed. That is how it is for the good sleeper – cue bed, cue sleep! That is where you want to be, I’m sure.

If you always sleep in your bed and if you only use your bed to sleep in, you can, even now, build a strong link between your bed and sleep. This connection will lead your bed to again becoming a cue for sleep, and so help to improve your sleep pattern. There are a number of things I can suggest that will help to make a strong connection between sleep and the bed.

Bedtime Activities

First, it is important not to use your bed for *anything except sleep*. This means that activities like watching TV, reading, eating, and talking on the phone are out! When you go to your bed, you should put the light out straight away and put your head down intending to sleep. Sexual activity is the only exception to this rule; it usually helps us sleep afterwards!

I know that lots of people read in bed. And I know it doesn’t directly cause insomnia if you read in bed, or speak on the phone. Sure, there are loads of people who read in bed without any problem. For you, however, it is very important that in rebuilding your sleep pattern you get into the way of *falling asleep very rapidly* after you get into bed. I want you to develop a quick bed/sleep response.

You can always read somewhere else, but from now on your bed is for sleeping.

The Quarter-of-an-Hour Rule

Of course, there will be nights when you put your head down and sleep will not come quickly. What I recommend here is that if sleep does not come within 15 minutes, you should get out of bed and go into another room. I know that, just like being awake when it seems like everyone else is sleeping, getting out of bed when you want to sleep is going to be very hard. It may be hard because you feel cozy and don’t want to leave the warmth of the bed. It may be hard to know what to get up and do. But there are things you can do to make getting out of bed easier – you could leave the heating on and a table lamp on in your living room. You could prepare a warm milky drink or a decaffeinated drink before you go to bed – because you *will* be awake for more than 15 minutes. You could read or listen to music, or do something else that is relaxing while you are up.

Again I want you to realize the importance of the bed/sleep link. By getting up from bed you keep wakeful time associated with a wakeful environment in the house. Importantly, you also get out of that habit of lying in bed and getting frustrated. If you are not sleeping, you are not sleeping. It is as simple as that. Get up and stop trying to sleep. Sleep will come when it is ready.

Let me say a word, though, about this 15-minute cut-off for lying in bed. First, you don't need to wait as long as that if you don't want to. If you don't feel sleepy it's OK to get up sooner. Second, I don't want you to count down the clock! That is why I call this the *quarter-of-an-hour rule*. This is meant to give you the idea of an *estimate* of the time after which you should be getting up. Good sleepers fall asleep easily within a quarter-hour of putting the light out, so if it's good enough for them, it's good enough for you too.

You should also follow this quarter-of-an-hour rule if you wake up in the middle of the night and cannot fall asleep again. In other words, if you follow this rule you should no longer lie awake in bed for any longer than 15 minutes. This too means that your bed/sleep connection is going to get stronger. Don't be surprised or dismayed if you are up and down quite a few times at first when you follow this rule – it is in a good cause.

Feeling Sleepy

It is important that you only go to bed when you feel sleepy enough to get to sleep quickly. If you are lying awake in your bed, you are breaking down the connection between bed and sleep, and you are building up a lot of frustration. So try and stay up until you feel *sleepy-tired*. That way you will be more likely to get to sleep quickly, and less likely to lie awake thinking about not sleeping.

How do you know when you are sleepy-tired? The usual signs are things like itchy eyes, lack of energy, aching muscles, yawning and a tendency to 'nod off'. It is important that you spot the difference between tiredness and sleepiness. Tiredness does not mean that sleep is inevitable, whereas sleepiness is a signal from our bodies that it is time for our night's sleep. We might feel tired but not be ready to sleep, so work on this a bit and see if you can identify clear signs of sleepiness that are typical for you.

The same point about feeling sleepy applies if you are up during the night, putting the quarter-of-an-hour rule into practice. After a while of being up, you should go back to bed *when you feel sleepy again*, but not before. If you still cannot sleep when you go back to bed, you will need to get out of bed yet again!

Avoiding Napping

Another thing to do to strengthen the connection between night-time sleep and your bed is to avoid napping during the day – or in the evening. I want to emphasize the importance of remembering that bed is for sleep and night is for sleep. *Daytime is for wakefulness*. This is a fundamental principle. If your sleep seeps into the daytime it is likely that being awake will seep into your night, and this will only make your insomnia worse. Stopping naps if you are in the habit of taking them will not only better prepare you for a continuous, longer sleep at night but will strengthen the connection between your bed and sleep. Sleeping in a chair or on a sofa in another room weakens that important link.

If you feel that you absolutely must have a nap, or if you fall asleep without wanting to, then you have to make sure that you don't have another type of sleep problem that is associated with excessive daytime sleepiness. I covered this in some

I know that I am hitting you hard with a lot of rules right now, so let's just take stock for a moment.

This is all about strengthening the bed/sleep connection so that it gets to be as it is for the good sleeper. In Table 12 I have left space for you to write down any decisions that you face concerning each element of the bed/sleep connection. Take some time to think through *how* you are going to apply each of these rules.

Try not to kid yourself that you will 'just do it' – you won't! This part of the CBT program is very challenging, so you need to consider carefully how you are going to achieve success in putting this aspect of your new sleep schedule into practice.

How Much Sleep Do I Need?

How much sleep do you *need*? The amount of sleep that you need may well be different from the amount of sleep that you want.

Everyone's sleep needs differ, so there is not a single answer to the question. For example, you might have a shorter sleep requirement than some other people. Although you might prefer to have brown eyes instead of blue, or to be taller or shorter in height, you will know that these are things you can't change. Similarly, your sleep pattern will work best for you when you accept you have to work within natural boundaries.

What is more, your sleep needs will have changed over the course of your lifetime. You have to be prepared to adjust your expectations, and so your behavior, accordingly.

A particular problem with insomnia is that sleep is likely to be upset in a way that makes each night different. For example, a person with insomnia may sleep 3 or 4 hours some nights, while on other nights manage to get 6 or 7 hours. In one way or another, insomnia is often a mix of bad nights and better nights, which is pretty frustrating. Another common problem is that difficulties getting to sleep and waking in the night break the sleep that you do get into bits. This will make it feel as if you have had even less sleep, even if the total time, added up, doesn't look so bad.

I imagine that it may be hard for you to know how much sleep you need, especially if your pattern is all over the place. Here's what I suggest in my clinic as the best way to find out how much sleep you need:

Using your Sleep Diary it is quite easy to work out how much sleep you are getting, on average, at the moment. First, write down in the spaces in Box 5 the amount of time you think you actually slept in total for each of the last 10 nights. Second, add up the total time you have slept across these nights. Third, divide the total by 10 to get the *average length of your night's sleep*.

Box 5 Calculating your average sleep time

Amount of time I slept

- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10

Total amount of sleep over 10 days = _____

_____ = _____

My average sleep time =

10

Before we move on to the next step, it is worth saying that you will probably have come up with a figure that is less than what you are aiming at. But this is just your starting point. So far we have only found out how much sleep you are getting. Remember that no matter how little sleep that adds up to, it will still be worthwhile sleep.

Follow the program with me and you will see how you can first of all get rid of your difficulties getting to sleep and staying asleep, and after that you can build up your total sleep time to the amount of sleep you actually need.

Setting Your Time in Bed

Your next goal is to work out a way of achieving the *same* amount of sleep *every* night. This is important because we should be aiming for a sleep pattern that you can rely upon – that is, one that is stable and does not vary much from night to night. We know that good sleepers can rely on having a consistent pattern, so this should be your goal, too.

We have found out the average amount of sleep that you have been getting. Now I want you to get this same amount every night, but in one continuous sleep. In other words, to get you sleeping right through!

Deciding on Your Rising Time

I always recommend that you should *anchor* your sleep around a *fixed morning rising time*. This anchoring is to stop your sleep from drifting and to help it to settle down to a reliable pattern. To do this, you should now choose a time in the morning that you will rise from bed. The time you choose is up to you, but it should be a time that you are comfortable with and that allows you to do all the things you need to do during the day. For example, you may find that 6:30 or 7:00 a.m. is a good time to set because during the week you need to get up then for work. Once you have decided, write this time down in Box 6.

You should now have both your average sleep time and your fixed morning rising time. The next thing to think about is when bedtime should be. At the moment, how do you decide when to go to bed?

Box 6 Rising time

My morning rising time is _____

Deciding on Your Threshold Time

Sometimes people go to bed before they are sleepy-tired and end up lying awake, or

they fall asleep quickly but wake up very early. At other times, people will go to bed early to try to catch up on the sleep they have lost on previous nights. People sometimes say that they go to bed because ‘everyone else has gone to bed’, or just because ‘it’s bedtime.’ People even force themselves to stay up very late in an effort to exhaust themselves, in the belief that this will make them sleep better.

However, the answer to the question ‘When should I go to bed?’ is fairly straightforward. You should go to bed at a time which makes it likely that you will sleep right through the night. The next step, then, is to set what I call a *threshold time* for going to bed. This is to mark the point at which you can cross the threshold from waking to sleeping. It is worked out by subtracting your average sleep time from your morning rising time.

Let me give you an example. Suppose someone has worked out that their average sleep time is 6½ hours, and that they have set their rising time at 7:00 a.m. By subtracting 6½ hours from 7:00 a.m. we get 12:30 a.m. The threshold time for this person, then, is 12:30 a.m. This person can then go to bed at this time, providing they feel sleepy-tired then. You should now work out your threshold time by following the steps in Box 7.

Box 7 Calculating your threshold time for considering going to bed

My threshold time is:

My average sleep time _____ – My set rising time _____ = _____

Please remember that your threshold time is *not* your actual bedtime. Your time for going to bed must always be at, or after, the threshold. Your threshold time is the *earliest* you can go to bed. I want you to monitor how sleepy-tired you feel and then to go to bed when you feel sleepy-tired and after you get to the threshold.

Summary of the Sleep Restriction Program

I think there is a very good chance that you will now be seriously worried! What times have you arrived at? It is likely that either you will feel that it is very early to get up in the morning, or that it seems very late to stay up until your threshold time. Maybe you even think that both will be a major problem. It is important, therefore, that you do not forget that I am trying to help you get a new and consistent sleep pattern going.

I want to make sure, however, that you don’t overdo things. Remember I said that sleep scheduling is based upon stimulus control and sleep restriction? Well, the bed/sleep connection advice I have given you is about the stimulus control part. Working out your sleep needs and your *sleep window* (when you can be in bed) is about sleep restriction. The goal is to maximize the chances that you will sleep right through. Sleep restriction is *not* the same as sleep deprivation. So, if you find from your Sleep Diary that your average sleep is less than 5 hours, I want you to work out your threshold time based on a *minimum of 5 hours in bed*.

You should now have all the information you need to decide on your new sleep schedule. Set the window to the size of your average sleep at the present time (or at 5 hours if your current average is less than 5 hours), and fix your morning rising time

and threshold time. If you would rather not get up so early, then fix your rising time for a bit later – but also stay up later. If you would rather get to bed earlier, that is fine, too – but you have to rise earlier.

A Nightly Schedule?

You may be thinking, ‘Surely he doesn’t mean that I have to do this *every* night, including weekends?’ Sorry, the answer is yes. You’re facing quite a challenge getting your sleep pattern sorted out, and it is going to take a *seven-nights-a-week* CBT treatment to do it. Your threshold time and your rising time are meant for *every* day of the week.

Let me explain a little more. The aim is to reset your sleep pattern and to increase your *sleep efficiency*. Remember that sleep efficiency is simply the percentage of time you spend in bed sleeping.

For example, Craig goes to bed at 11:00 p.m., but does not fall asleep until 12:30 a.m. He also is awake for 30 minutes in the middle of the night. So when Craig wakes up at 7:00 a.m., he has slept for 6 hours but he has been in bed for 8 hours, having been awake for a total of 2 hours. Craig’s sleep efficiency score is the number of hours he has slept (6) divided by the number of hours he has spent in bed (8), multiplied by 100. This gives him a sleep efficiency of only 75 per cent.

If you slept right through from the moment your head hit the pillow until the moment your alarm clock went off you would be sleeping 100 per cent of the night! The sleep-restriction program I have described for you actually gives you the chance of reaching that 100 per cent, at least some nights, because homeostatic pressure for sleep (your sleep drive) will build up as you follow the program every night. Sleep inevitably will fill in the only gap you make available to it – your new ‘sleep window’. In practice, though, I want to help you to increase your sleep efficiency to around 90 per cent. That is an achievable goal. I accept that weekends will be hard for you, so use your alarm clock to make sure you rise at your fixed time.

I have summarized the sleep-scheduling component of the CBT program in Box 8 so that you can put it all together. You will see that I have added some questions to help you think about each instruction in practical terms. I suggest that you sit down with your notebook and write down your answers to each of these questions, and that you problem-solve any that are likely to pose a particular problem. If you have a partner or there are others in the house with you, it can be a good idea to discuss these solutions with them. I have found that people with insomnia are often worried, for example, about getting out of bed when they can’t sleep, in case it disturbs the household. By discussing solutions with others involved I think you will find that they will often be happy to support you in trying to solve your sleep problem – whatever it takes.

Box 8 Summary of the sleep scheduling program

1. Stay up until your threshold time.
(When is that? How are you going to use your extra time in the evening?)
2. Lie down in bed only when you feel sleepy.
(What are your signs of sleepiness?)
3. Do not use your bed for anything except sleep.

(What changes are you going to have to make?)

4. If you do not get to sleep quickly (within 15 minutes), get up.

(What exactly will you do when you get up? What preparations do you need to make before you even go to bed?)

5. If you still cannot fall asleep, repeat Step 4.

(What exactly will you do?)

6. If you wake during the night, repeat Step 4.

(What exactly will you do?)

7. Get up in the morning at your rising time.

(How will you make sure?)

8. Do not nap during the day or evening right up to your threshold time.

(How are you going to make sure you avoid napping?)

9. Follow this program seven days/nights a week.

(How will you manage this?)

It Feels Like Surgery!

I mentioned to you in Part One that I say to some patients with insomnia that I think their sleep problem is worse than they do! Requiring, if you like, special treatment. Well, here it is.

I know that the sleep scheduling is going to be tough for you. I sometimes call it ‘the surgical option’ because it is a bit like cutting out an old and malfunctioning part and implanting a replacement.

Changes can be difficult to put into practice, and they can be even harder to keep going. You may find that the first few nights are not too bad and that you manage without difficulty. However, you will definitely be tempted at times to forego the quarter-of-an-hour rule, for example.

It is at times like these that you have to make that extra effort and stick to your new sleep schedule. You have to remember that your insomnia is a tough problem to overcome, and that if the CBT program is to work for you, you have to follow it the way it was designed. I have to say that it is only by maintaining the changes you have put in place that your sleep pattern can be improved. So it is important that negative thoughts such as ‘I am never going to get a good night’s sleep’ are replaced with more positive ones such as ‘This problem is hard to break, but I am going to keep on following this program because it has been shown to be effective for people like me.’ *Keeping motivated* is the key to achieving permanent changes in your sleep pattern.

The diagram I produced for you in Chapter 5 (Figure 10, p. 81) showed you the process of making changes when it is hard to do so. Have another look at that now, and re-read that earlier section. Your motivation will come and go; that is to be expected. Relapses will occur some nights when you just can’t follow the plan. These are times when you will experience a strong feeling of disappointment in yourself and think that there is no point trying again. Please don’t let relapses discourage you. They are normal. The best thing to do is to get right back on course. I honestly think you may never have a better chance to sort out your sleep problems.

Making Adjustments in Sleep Scheduling

‘But am I going to get stuck with this short sleep window?’ I hear you ask. I don’t expect that you will get stuck. I hope that you will end up getting more sleep because, once your pattern adjusts, you can begin to lengthen the amount of time you spend in bed.

At first, the idea is that by restricting the amount of time you spend in bed you will be able to sleep right through. Instead of having bits of sleep, I want to see it all squashed together. But then we can let it grow a bit bigger, hopefully to the amount you would like . . . or at least to the amount you need.

Your guide here, again, is your sleep efficiency. Once you are sleeping 90 per cent of the time you are in bed (threshold time to rising time) for one full week, you can increase your time in bed by 15 minutes for the next week, by either going to bed 15 minutes earlier or staying in bed 15 minutes later in the morning. After trying that out for the next week, you can check if you still make it to 90 per cent. If you do, then you can increase your sleep window by another 15 minutes. But please note you must be very strict and not go above 15 minutes per week at any time. You can make these adjustments several times perhaps, but you will come to the point when you are in fact sleeping as much as you need. At that point, trying to spend longer in bed will not give you any more sleep and you have achieved your established pattern. Here is an example:

Carolyn has been following a 6-hour sleep window and is now managing to sleep an average of 5½ hours per night. When she does the arithmetic, her sleep efficiency is now over 90 per cent $(5.5/6) \times 100 = 91.7$ per cent. So, during the next week she can increase her sleep window to 6 hours and 15 minutes. She can either set her alarm for 15 minutes later, or she can go to bed 15 minutes earlier. She cannot do both. This new schedule can then be followed for a further week to see if she is able to sleep even longer.

Monitoring Your Sleep

I know that I keep reminding you about the importance of your Sleep Diary as you go through the program. Now you will see one of the reasons why. Your diary information is very valuable in making the adjustments you need to make. Remember to work on all the material you have covered in this chapter for a full week before going on to the next section.

Dealing with a Racing Mind (Program Week 5)

Introduction

So often people have said to me that their main problem is not being able to empty their mind . . . not being able to stop their thoughts from racing. Sometimes they say that they feel physically exhausted but they just cannot seem to switch off mentally. Indeed, research studies have shown that people with insomnia are actually more aware of *mental* symptoms of arousal than they are of *bodily* (physiological) symptoms. I wouldn't be surprised, therefore, if you had flicked open to the Contents page of this book, spotted this chapter, and headed straight here.

Of course, as I keep reminding you, this is a course of treatment, a program of CBT. So I don't want you to pick and choose. Nevertheless, I am sure that many of you who are using the program will find this chapter particularly important and helpful too.

I am going to take you through the strategies that we teach our patients to deal with thoughts and worries related to sleep. I will also introduce some of the assessment measures that we use, so that you can sort out the type of thought problems you are having, and so can find suitable solutions.

Aim

The purpose of this session is *to learn ways of overcoming the mental alertness, repetitive thoughts and anxieties that interfere with your sleep.*

Knowing the Enemy

As I was just saying, research has shown that people with insomnia complain a lot about an overactive mind in bed. They may or may not be the kind of people who have an overactive mind in the daytime, too. Some people seem to get into the habit of using their time in bed as a time to think things through. Maybe they lead busy daytime lives and just run out of thinking time! Others find that it is impossible to keep their minds empty when it is quiet and they can't sleep, and then they get preoccupied with their own thoughts – however important or trivial they may be. The busy and racing mind is the enemy of sleep.

First of all, then, let's consider the kinds of things that you think about when you

are in bed and unable to get to sleep. There are several types of thoughts that are common, so I want you to consider each of these to see if they ring a bell.

Rehearsing and Planning Thoughts

As the name suggests, this is when you think back over the day or recent events, or when you look ahead to things that are about to come up. Replaying the day's events at the end of the day is in some ways quite a natural thing to do. Perhaps it is even enjoyable at times! It just so happens that the night separates one day from the next, so at the close of the day it is normal to reflect on what you did and on how things went. Likewise, thinking ahead to the next day and planning ahead to future events may be on your mind. Tomorrow is, after all, a new day, with all its activities and responsibilities. You may find you go into checklist mode. If so, you are likely to find yourself anticipating, either positively or negatively, the day ahead. My point is that your rehearsing and planning thoughts might keep you awake simply because they cause mental alertness in bed.

Problem-solving Thoughts

You may have things on your mind because you think this or that 'needs to get sorted out'. This kind of thought pushes itself to the front of your mind because it carries with it a sense of urgency. There's a problem, or at least a perceived problem, and you must find a solution. So you stay awake while you try to come up with an answer. It could be that you are able to keep things in the back of your mind during the day, but at night, because you are not occupied with other things, these thoughts begin to dominate. These thoughts often require some concentrated attention because there may be options to think through properly before you can make a decision or a plan. That's why they are really best dealt with during the day, when you are awake. If *problem-solving* is part of your night-time routine, little wonder that you have difficulty sleeping. In this type of thinking there's no doubt that your mind will actually be working quite hard. So it's a recipe for staying awake, because when we are tired and cranky we really don't solve problems very well. Then, of course, we realize that we are not coming up with a good solution, which makes us get caught up all the more in mental and emotional alertness.

Thinking about Sleeping

You may feel that you don't really have any problems . . . except the insomnia problem! *Thinking about sleeping*, or more likely, thinking about the fact that you're *not* sleeping, is very much part of every insomnia problem. It's part of the vicious circle – I want to sleep – I can't sleep – I can't stop thinking about wanting to sleep – so I'm keeping myself awake. When sleep doesn't come quickly or naturally you may well find that you become preoccupied with your sleeplessness. But there is probably more to it than that. You begin to think about the *consequences* of not sleeping. 'How am I going to get through tomorrow?', 'If I don't get to sleep soon I will only have had a few hours sleep,' and so on. These kinds of thoughts often lead

us to try too hard to get to sleep.

Listening to Your Body

This is a bit like the last one. What I mean by *listening to your body* is that you start to focus inwards and notice how tired you are, or how awake you are. Maybe you can't stop listening to your heart beat; it thumps away in your ear as you lie on your side in bed. Or some other body sensation like feeling hot or cold, or an annoying itch, or restlessness in your legs, or muscle tension. You get the idea – you are 'tuned into' your body, as if you are undertaking a detailed observational study of yourself. This kind of thinking can make us very restless in bed. Thinking about your health would come into this category too, especially after a period of illness, when it is quite natural to find that you are preoccupied with your health. These are all examples of *self-awareness* thoughts, when your mind is quite concentrated and focused, and is not good for getting off to sleep.

Thinking about Thinking

This is quite an important one because, many times, people with insomnia are at pains to point out that they *don't* have worries or depression and that everything really is fine. The frustrating thing for them is that they know that the thoughts keeping them awake are absolutely trivial. Do you do this *thinking about thinking* sometimes? When your mind buzzes around, darting from idea to idea? Usually the ideas, thoughts or images are silly or unimportant, and you might then think 'Why on earth did that come into my head?' The trivial nature of these thoughts can then become a focus in itself because it is intensely frustrating to feel that you are dominated by nonsensical or unimportant thoughts. Commonly, with these types of thoughts you may feel that you can't control your thinking, even though you are not really worrying about anything. Feeling that control is slipping away is not good for relaxing into sleep.

Thinking about Things that Go Bump in the Night

I would say that this is really not a major feature of insomnia, but it does sometimes happen that people become anxious or preoccupied by things in their environment at night. I don't really mean ghouls and ghosts, just that sometimes people can't get to sleep because of noises they hear, or think they hear. The wind outside, people in the street, an unfamiliar sound that you can't explain to yourself – because your senses home in on what you have noticed (you may even hold your breath to listen more intently), it becomes very hard to sleep.

Thoughts and Emotions

It is not very realistic to try to separate our thoughts from our emotions. I would advise you to consider how you are feeling as well as what you are thinking. Our

mind is a *combination* of thoughts and feelings. Maybe there are worries in your life at the moment, about family, work, health, money or whatever. So when you are having your rehearsing, planning type of thoughts, or your problem-solving thoughts, you may find that you get strong emotional feelings. Of course, the thoughts plus the feelings keep you even more awake. Disappointment, sadness, guilt, frustration, and worry in our thoughts make sleep so much more difficult. If you are feeling emotionally drained or strained, it may be even harder to deal with your lack of sleep. It is, of course, important to work out if there is a separate problem with your emotions that needs help in its own right. The CBT program can help your insomnia, and that will surely help how you feel, but remember that it is not a treatment for depression or for other emotional or mental health problems.

On the other hand, I am not trying to imply that you do have a serious emotional problem. I believe people when they say they have nothing to worry about; even lots to be grateful for. You may not be unhappy or anxious in your life or with yourself in a general sense. So it is particularly frustrating when you can't find the final piece of the jigsaw. Certainly, not being able to get to sleep does get us emotional. At times your frustration may even turn to annoyance or anger. You lie there thinking about how you can't get to sleep, perhaps knowing that you are keeping yourself awake. You are actually winding yourself up emotionally!

Measuring the Content of Your Thoughts

I hope this is helping you to 'assess the enemy'. To help you a bit more I have reproduced for you in Figure 14 a simple rating scale called the Glasgow Content of Thoughts Inventory (GCTI). This came from work we have done with people with insomnia, which helped us to find out the most common thoughts that were in their minds as they tried to fall asleep. The best way to use the scale may be to photocopy it so you can use it more than once.

You just follow the instructions and give a rating for each item. That will give you a profile of the kinds of thoughts that interfere most often with your sleep. You will see that you can also add up the scores to a total score and to three sub-scores. The three sub-scores are items that relate to one another under a general heading. You can calculate, using these, which area or areas you have the most problem with. Spend a little time completing the GCTI now.

Another use of the GCTI would be to fill it in every few weeks to see if your scores are getting any lower. Think of the GCTI as giving you target areas to work on, and also as a way of measuring your progress in tackling these targets.

OK, so we have spent quite a bit of time on trying to understand and measure the types of thoughts that may be causing you some trouble. What can we do to overcome a racing mind?

Here are some thoughts that people have when they cannot sleep. Please indicate, by placing a tick in the appropriate box, how often over the past seven nights the following thoughts have kept you awake.				
Thought	Never (0)	Sometimes (1)	Often (2)	Always (3)
1. Events in the future				
2. How tired/sleepy you feel				
3. What happened during the day				
4. How nervous/anxious you feel				
5. How mentally awake you feel				
6. Checking the time				
7. Trivial things				
8. How you can't stop your mind from racing				
9. How long you've been awake				
10. Your health				
11. Ways you can get to sleep				
12. Things you have to do tomorrow				
13. How hot/cold you feel				
14. Your work/responsibilities				
15. How frustrated/annoyed you feel				
16. How light/dark the room is				
17. Noises you hear				
18. Being awake all night				
19. Pictures of things in your mind				
20. The effects of not sleeping well				
21. Your personal life				
22. How thinking too much is the problem				
23. Things in your past				
24. How bad you are at sleeping				
25. Things to do to help you sleep				
<p>Total score: add items 1 to 25 (note the maximum score is 75)</p> <p>Sub-scale 1: focusing on rehearsing/planning/problem-solving. Add items 1, 3, 8, 12, 14, 15, 19, 21 and 23.</p> <p>Sub-scale 2: focusing on your sleep and wakefulness. Add items 5, 6, 7, 9, 11, 18, 22, 24 and 25.</p> <p>Sub-scale 3: focusing on your self and sensory awareness. Add items 2, 4, 10, 13, 16, 17 and 20.</p>				

Figure 14 The Glasgow Content of Thoughts Inventory (GCTI)

Can I Make the First Strike?

I'm sticking with the analogy of a battle, because I think that's the way people often experience it! What do I mean by a *first strike*? I mean a pre-emptive one. By getting in first, before thoughts and anxieties have the potential to disrupt your night, you might be able to save yourself quite a bit of upset.

Putting the Day to Rest

I think you may find this technique particularly useful for thoughts that have to do with the past day and thoughts relating to planning for the following day. The aim is to put the day to bed, along with all your plans for the next day, long before bedtime . . . so that when bedtime comes you can get to sleep. If you can manage to deal with the kind of thinking that you usually do in bed before it happens, then you should sleep better.

I call this technique *putting the day to rest*. Here is what is involved. Simply follow the steps I have summarized in Box 9. Twelve steps may seem a lot, but honestly you can do this in 20 minutes, no problem. You just have to make the time and get into the discipline of putting the day to rest before the evening really gets going. Remember that the thoughts that interfere at bedtime will be so much easier to dismiss if they have already been dealt with . . . at a time when you were much more awake.

Using Your Knowledge to Combat Worry

I hope you have been getting better at using what you now know to evaluate your thoughts and attributions. This is just a reminder to keep using those techniques I taught you before. Are you remembering to use your thought-evaluation form (Table 8, p. 101)? Your outlook upon your sleep and your attitude towards sleeplessness are so important. These things are also part of your pre-emptive strike force. *You* are in charge of the amount of damage that a poor night's sleep can do to you, because a lot of that depends on your *perspective*. I would encourage you to re-read that section of the book at this point.

Box 9 Putting the day to rest

1. Set aside 20 minutes in the early evening, the same time every night if possible (say around 7 p.m.).
2. Sit down somewhere you are not going to be disturbed.
3. All you need is a notebook, your diary, and a pen.
4. Think of what has happened during the day, how events have gone, and how you feel about the kind of day it has been.
5. Write down some of the main points. Put them to rest by committing them to paper. Write down what you feel good about and also what has troubled you.
6. Write down anything you feel you need to do on a 'to do' list with steps that you can take to tie up any loose ends or unfinished business.
7. Now think about tomorrow and what's coming up. Consider things you are looking forward to as well as things that may cause you worry.
8. Write down your schedule in your diary, or check it if it's already there.
9. Write down anything you are unsure about and make a note in your diary of a time in the morning when you are going to find out about that.
10. Try to use your 20 minutes to leave you feeling more in control. Close the book on the day.
11. When it comes to bedtime, remind yourself that you have already dealt with all these things if they come into your mind.
12. If new thoughts come up in bed, note them down on a piece of paper at your bedside to be dealt with the following morning.

Turning the Tide

Of course you need tools to help you when you are in bed, too. Here are some of the

ones that are most effective for my patients.

Thought-blocking

I have found that people with insomnia find this technique works best with the trivial, less important thoughts rather than with more worrying or more serious problems. Sometimes trivial interrupting thoughts come to people when they wake up in the middle of the night. When this happens, it is best to start the thought-blocking immediately upon waking before you get too wide awake! Thought-blocking involves following the three simple steps I have summarized in Box 10.

Box 10 Three steps to successful thought-blocking

1. Repeat the word 'the' every 2 seconds in your head with your eyes closed.
2. Don't say it out loud, but it sometimes helps to 'mouth' it.
3. Keep up the repetitions for about 5 minutes (if you can!).

Thought-blocking works by stopping other thoughts from getting in. As the term suggests, it creates a block. But why should this work? Well, the word 'the' is, of course, meaningless. So when you repeat it to yourself it doesn't have *any* emotional effect, except maybe to bore you . . . and that might actually help!

Let me give you an illustration of how a small amount of information repeated to yourself can stop other information getting in. Suppose you have looked in the telephone directory to find a number to call, but the phone book is in one room and the telephone is in another. You decide just to try to remember the number, so you walk to the phone rehearsing the number over and over to yourself. As you walk through the hallway, someone in your family is there and just says 'Hi'. What happens? You really can't respond, you can hardly even look at them . . . because your total mental capacity is taken up with repeating just a few numbers.

Give the thought-blocking technique a good try and see how you get on with it. Thinking the word 'the' to yourself slowly and calmly every two seconds really helps you disconnect not only from the outside world, but importantly, also from your own thought processes.

Relaxation and Imagery

During Week 2 of this program you learned about how to use a relaxation routine. Relaxation is a good way of relaxing the mind, as well as the body. This is because it is a pretty good *distraction technique*. It helps you focus your mind away from intrusive and worrying thoughts. I think it may help you deal with the kind of thoughts that dart around all over the place. Relaxation exercises can give you more of a sense of being in control – of your breathing, your muscles, your mind. It is in this sense a good tool to have in life as a coping response whenever you feel under pressure.

What I want to do now is introduce something called *imagery*. This can be bolted on quite easily to your relaxation exercises. Imagery involves creating a mental picture, a kind of visual story in your mind. I would imagine many of you will have tried this when you can't get to sleep at night. You try thinking of something

pleasant, maybe a peaceful place you know, or a holiday you enjoyed somewhere. The old idea of counting sheep and watching them jump the gate is an example of imagery. So this is the general principle of what I mean, but there is evidence to suggest that this kind of ‘thinking something up’ imagery is not very effective. Maybe you have found that too?

The research data tell us that, in order to be effective, imagery should be *planned* in advance and should be well *practised*. Some of the essentials for imagery training can be found in Box 11.

Box 11 The essentials of imagery training

- **Be prepared** – don’t just wait until the time comes and try to think something up. Develop a screenplay! You are the director, so shoot the scenes and edit them until you have got what you want. Your imagery sequence should take about 10 minutes to go through in your mind’s eye.
- **Practice regularly** – you are also a participant! You must learn the scenes and the sequences so that they flow as the movie rolls! You need to set time aside to learn the ‘script’ and you should practice in the evening or during the day too.
- **Get good quality images** – vivid and clear in your mind’s eye is what you want. Notice the colours, the smells, the sounds, the sensations that you make part of your imagery routine.
- **Relax and enjoy!** – who wants to watch a movie that is uninteresting? This is something that you should look forward to. But at the same time remember you want to develop an imagery story that is calming, soothing, and not evocative of strong emotions!

I suggest that you follow your relaxation routine and then follow straight through into your own imagery story. You can also practice joining them up. As you get better at using imagery you will find that it is another good distractor from unwanted intrusive thoughts and emotions because it captures your attention.

Sleep Scheduling

You have already begun to establish a new sleep habit because you are following the sleep-scheduling part of the program. Why am I mentioning sleep scheduling in this section too? Simply because many of these behavioral rules are also very effective against a racing mind.

For example, staying up until you are sleepy-tired means that you are more likely to fall asleep quickly rather than lying awake thinking. In the same way, getting out of bed if you are awake for quarter of an hour means that you will have less thinking time in bed . . . and that is a very good thing! Remember we spoke about building up a strong bed/sleep connection. The sleep-scheduling program will help you remove thoughts and emotions that occur at night into another part of the house. This should mean that sleep is less interrupted by your mental overactivity. So keep up the good sleep-scheduling work that you have already started!

Giving Up Trying to Sleep

Sometimes people are unable to sleep because they are simply trying too hard. We spoke before about *sleep attention*, *sleep intention* and *sleep effort* in this regard. Trying to fall asleep actually keeps you wakeful and leads to irritability when you don’t succeed. It is understandable that you want to sleep and then try to make it happen. The drawback is that, unlike many other things in life, sleep is not something

that you can *make* happen by sheer force of will. In fact, the harder you try, the less likely it is to happen. But how do you give up trying to sleep? I have found that two methods work; you can decide which of them suits you best (Table 13). You may think, looking at Table 13 over the page, that I have finally taken leave of my senses! But if there is a madness in my method, there is also a method in my madness! Let me explain.

The use of *humour* is extremely powerful in helping us to take a different perspective. If we need to *de-catastrophize* a situation, that is to reduce all our exaggerated conclusions and emotions, then humour presents a good way forward. This is in part what I mean by ‘turning the tables’. Try to think ‘What is the worst that can happen?’ and then challenge the true likelihood of all your wild imaginings. Try going with the flow instead of against it by posing less resistance to wakefulness. Accept that you will just get up if you are awake. Big deal – so do something with your extra time!

Table 13 Methods for giving up trying to sleep

Method 1 Turn the tables	Method 2 Try to stay awake
<ul style="list-style-type: none">• Take every opportunity to be carefree about your insomnia.• Relish opportunities to get out of bed whenever you can.• Try to imagine as many catastrophes as you can that will happen, just because you are awake at night. See them as exaggerated and absurd.• Be prepared to accept you have insomnia. Even tell others about it.• Think of wakefulness as an opportunity, not a disaster. Use the time when you are up, to do something useful or something you enjoy.	<ul style="list-style-type: none">• Lie comfortably in your bed with the lights off, but keep your eyes open.• Give up any effort to fall asleep.• Give up any concern about still being awake.• When your eyelids feel like they want to close, say to yourself gently ‘Just stay awake for another couple of minutes, I’ll fall asleep naturally when I’m ready.’• Don’t purposefully make yourself stay awake; but if you can shift the focus off attempting to fall asleep, you will find that sleep comes naturally.

This is Method 1. It may or may not appeal to you, but I hope that you can see that a more light-hearted approach could help to reduce anxiety and effort around sleep. Patients using this approach often talk about developing a completely different attitude. Indeed, the idea of accepting situations rather than fighting them all the time has its roots in a number of ancient philosophies and religions. *Acceptance* leads to a problem having a less dominating position. Where sleep is concerned, a more mellow perspective is an adaptive outlook, and one that can lead to improved sleep.

Method 2 is an even more *paradoxical* method. In psychology we use this term to describe therapies where you are encouraged (paradoxically) to keep the symptom going, rather than trying to eliminate it. With insomnia you change your goal to that

of staying awake, instead of getting to sleep. By deciding to stay awake you are *completely giving up trying* to sleep. When that happens you find yourself falling asleep in spite of yourself. How reassuring it can be to find that you are overtaken by sleep. ‘I don’t know what happened last night, I was trying to stay awake just a few minutes longer and the next thing I knew it was morning.’ That is the kind of thing that patients say when this method works for them.

Making Less of an Effort

The two methods in Table 13 have the same goal – to help you give up trying to sleep. Letting sleep strengthen and develop again naturally will take you closer to your goal of being a good sleeper. The Glasgow Sleep Effort Scale (GSES) as a way of summarizing and scoring the sleep effort problem. I have reproduced the GSES for you in Figure 15 (over the page).

Why don’t you fill it out just now, to represent the way you *usually* feel about your sleep? Hopefully you will see that the items in the scale reflect the habit of *sleep preoccupation* and *sleep effort* I have been talking about. Do you see from your score how over-involved you have become with your sleep? Now ask someone you know who is a good sleeper to fill it out. See what they score and make the comparison. Good sleep is pretty much effort-free!

I would like you to reduce your effortful approach to an effort-free approach by using Methods 1 or 2 (or both), and of course by keeping going with all the other parts of the CBT program. You can always fill the GSES in again at some point to see if you are getting closer to becoming a good sleeper!

The Glasgow Sleep Effort Scale

The following seven statements relate to your night-time sleep pattern *in the past week*. Please indicate by circling *one* response how true each statement is for you. Score 0 for ‘not at all’, 1 for ‘to some extent’ and 2 for ‘very much’, then add up your total score (maximum is 14)

1. I put too much effort into sleeping at night when it should come naturally.

T012Notatallto some extentvery much

2. I feel I should be able to control my sleep at night.

T012Notatallto some extentvery much

3. I put off going to bed at night for fear of not being able to sleep.

T012Notatallto some extentvery much

4. I worry about not sleeping if I am in bed at night and cannot sleep.

T012Notatallto some extentvery much

5. I am no good at sleeping at night.

T012Notatallto some extentvery much

6. I get anxious about sleeping before I go to bed at night.

T012Notatallto some extentvery much

7. I worry about the long-term consequences of not sleeping at night.

T012Notatallto some extentvery much

Figure 15 The Glasgow Sleep Effort Scale

Are You Paying Attention?

Do you remember the story about my car having a blown headlight, and then my noticing all the oncoming vehicles that also had one of their headlights out? That was a story about *attentional bias*. My focus of attention had been directed, without me really being aware of it. We drew parallels with the sleep attentional bias in insomnia. So how can you reduce your unhelpful focus on sleep and sleeplessness?

First of all let me say that many of the techniques we have covered will help with this. Feeling more prepared by putting the day to rest and having a pre-bedtime routine means that the prospect of sleep is less threatening because you will feel more in control. Relaxation, imagery, and thought-stopping give you distraction methods away from the focus on insomnia. The sleep-scheduling techniques will lead you to spend less time lying awake in bed aware of not being asleep. Have another skim-read back over the techniques I have recommended, and figure out for yourself how *CBT draws attention away from concern about insomnia*.

Chief among additional things that might help is abandoning *clock-watching*. So many people over the years have said to me things like ‘I see every hour’ or ‘When I wake up and look at the clock, I can’t believe it’s only (whatever time).’ People with insomnia use clocks, not just to tell the time, but as performance indicators! They are part of the *self-monitoring tendency* that heightens arousal in bed and usually leads to negative self-evaluation.

Here is the kind of scenario I am thinking of in Table 14. Can you see how the clock becomes a trigger that ends up with an emotional response that is arousing? Your awareness of time often gets linked to an automatic and dysfunctional thought. Because these thoughts usually contain verbs that carry a value judgement (like ‘I *should* . . .’) the next consequence is that you will evaluate yourself negatively, and this leads to a strong emotional response.

Table 14 The problem of clock-watching

Awareness of time	Dysfunctional thought	Self-evaluation	Emotional response
<i>‘Look at that, it’s gone 12:30 . . .</i>	<i>. . . and I should be well asleep by now’</i>	I have failed	Annoyance
<i>‘I’ve been lying awake for almost 2 hours now and only caught a few minutes’ sleep . . .</i>	<i>. . . if I don’t sleep soon I’ll be wrecked tomorrow’</i>	I have lost control	Anxiety
<i>‘Awake again . . . so what’s the time now? . . . great (!) 4 a.m. . . .</i>	<i>. . . I can’t stand this any more; I’m going to go mad’</i>	I can’t cope	Despair

There are three solutions to clock-watching. The first two suggestions are fairly obvious. The advantage of removing the clock is that you are not so tempted to take a peek. The advantage of turning it away is that you can, when appropriate, make occasional time checks. An example of this is using the quarter-of-an-hour rule. You are not meant to monitor time exactly, but on the other hand I don’t want you to create an excuse for lying awake for ages before you get up! The final possibility is that by not allowing the clock to trigger negative thoughts you could decide to

challenge your usual *automatic thought* and your *self-evaluation*. Try to take an alternative perspective that is less upsetting and arousing. We have spoken about appraising your thoughts more accurately, and this is another opportunity to change the way that you think. I would recommend the combination of turning the clock away and using the trigger differently for starters, and see how you get on.

Evaluating How You Feel in the Day

Have another look at your scores on the Glasgow Content of Thoughts Inventory (p. 145). I want you to have a particularly close look at items that relate to the links you make between your sleep and how you feel in the daytime. Items 12, 14, and 20 are examples. How did you score on these? Do you think that a major part of your insomnia problem lies in how you feel in the daytime following a poor night's sleep?

There are two solutions to this that I can think of, so you should probably use both. *Optimizing your sleep pattern* means following the CBT program, particularly sleep scheduling, as best as you can. You can be confident that as your sleep improves, benefits to your daytime life will follow! If you want to measure what I mean by this idea of optimizing, I suggest you check again on your sleep efficiency. Remember that this tells you about the percentage of time you spend in bed asleep. So, keep working on improving your sleep efficiency.

The second part of the solution is *evaluating your beliefs*. You need to be willing to question the conclusions you draw about *why* you are not at your best in the daytime. I'm not saying that it's nothing to do with your insomnia – but there might be other factors too. You need to find out about those. Have a look back this time to the sleep quiz at the start of Part Two (p. 85). The answers I gave to questions 6, 7, 10, and 12 might help you here. Also keep using Table 8 (p. 101) and remind yourself of the examples I gave you in Table 7 (p. 100).

Making Adjustments

While we are on the subject of sleep efficiency, this is a good time to remind you about the rules for adjusting your sleep schedule week by week. Remember your sleep efficiency is the key here, too. If after this week you are sleeping 90 per cent of the time you are in bed (threshold time to rising time), then you can increase your time in bed by 15 minutes for next week. You can either go to bed 15 minutes earlier or you can stay in bed 15 minutes longer in the morning.

Monitoring Your Sleep

Another gentle reminder about the importance of continuing to use your Sleep Diary. I hope you are seeing progress as you follow the whole CBT program. Work away at the materials in this chapter for one week before moving on to Chapter 10.

Putting it All Together (Program Week 6)

Introduction

Well, I have covered most of the CBT materials now. This week's program is very much about learning how to put it all together and keep it together. Of course, I have emphasized this on the way through, but in this final week (Week 6) I want to illustrate how an integrated program can be achieved.

I would also point out that, although this is the last week of the program, you need to persevere for as long as it takes to overcome your insomnia and to become a good sleeper!

Aim

The purpose of this week is *to put together all the advice from the previous weeks and to help you to keep going with the program.*

Don't Pick and Choose

Try not to turn your nose up at things before you have really found out if they work for you. Some parts of CBT may at first look a bit unattractive, even a bit unsavoury. But an acquired taste is no bad thing, especially if it is good for your health, and especially your sleep.

Apologies if I have overdone the food analogy, but if you only remember the message because it is 'corny' I don't mind too much. I do want you to follow my recommendations, so here they are – all 32 of them! And these ingredients are *all* intended for you.

The CBT Program in Brief

You may want to photocopy Box 12 (pp. 162–4) as a reminder of what we have covered. This is your *step-by-step summary* for implementing CBT to overcome insomnia. I think it speaks for itself.

Developing a Confident Approach

A good sleep pattern may take quite a number of weeks to establish. You must be prepared for this. It is important, therefore, that you recognize the progress you are making along the way. There are two ways of measuring progress. First, are you getting better at *implementing* the program? If so you are definitely making progress! Second, is your *sleep pattern* improving? You won't get the second without the first, so let's start with the implementation part.

Use the first column in Table 15 (p. 165) to write down what you have achieved so far. The simplest way would be to note down the item numbers (1 to 32) that you are now managing to put into practice. Put the date at the top of the sheet, so you know where you stand right now. You can fill it in again in a couple of weeks and make a comparison, so again you might want to make a copy of Table 15 or put the information in your notebook instead.

I know from experience that it won't be all good news. So write down the item numbers that are still not achieved (or not fully achieved) in the second column. Everyone finds some parts of the program more difficult than others. Don't be too discouraged by that. Instead, let's consider the reasons why.

One possibility is that some of the advice may not be particularly relevant for you. If that is the case, then you can shift that item number into the third column. For example, maybe you never did drink coffee, or don't have naps in the daytime anyway. Perhaps you don't have any problem falling asleep, so some of the things to do at bedtime don't seem necessary. If this is the kind of reason then it won't matter too much. But just be sure you are not cheating with the items you are putting into column three.

Another possibility is that you can't quite get a grip of some part of what you are meant to be doing. My advice here would be to go back and re-read the relevant sections of the book, and discuss anything you are confused about with someone you trust. I hope that this will clarify any points for you.

A third reason may be simply that what you are being asked to do is hard. It may be hard to remember some part of the program because of old habits that are difficult to break, or it may be hard to motivate yourself to do something, or to stick at it. For example, it is not easy to get up out of bed if you don't fall asleep within a quarter of an hour, or to rise at the same time seven days a week. It can be very hard to change our behavior. Likewise, we have to be quite strong in our minds to challenge negative and pessimistic thoughts so that they become more accurate and more encouraging . . . and it is not easy to give up trying to sleep!

You may feel a bit disheartened by the middle column where you have written down the list of items that you are a bit stuck with right now. All I can say is that I would be astonished if you were already managing to put all of the instructions into practice all of the time! So, well done for all that you *are* doing. Try to be encouraged rather than discouraged. Be firm but fair with yourself for what you have achieved. Nevertheless, you have an agenda there to work on. Why don't you set some goals for implementing the tricky bits? Use your notebook to record your goals.

I hope your confidence is building now that you have a program for overcoming your insomnia. I hope your confidence is growing, too, because your sleep has shown some improvement. Now would be a good time to revisit the goals you wrote down at the start for what you were wanting to achieve. Are you getting closer to your goals? Remember they were to be *achievable* and *measurable*. Now is also a good

time to measure your progress. Have you been sticking at using your Sleep Diary?

Box 12 Overview of the CBT Program for Overcoming Insomnia

Some basics

- Think of insomnia as a bad habit that can be corrected and stick to the program until you establish a good habit.
- Consider gradually reducing any sleeping pills that you take, but consult your physician first to agree a plan.
- Get a comfortable bed and mattress suitable to your needs and preferences.
- Work out your sleep schedule, your average sleep length, your planned rising time and threshold time for considering going to bed. Threshold time can be calculated by subtracting the average duration of your sleep at present from your planned rising time.
- Always follow your planned sleep schedule 7 nights a week.
- Make adjustments to your schedule at a maximum rate of 15 minutes per week and only after your sleep efficiency, the proportion of time spent asleep when in bed, reaches 90 per cent.

Before you go to bed

1. Take light exercise late afternoon or early evening.
2. Put the day to rest long before bedtime. Think it through, tie up 'loose ends' in your mind and plan ahead. A notebook and diary will help to record and plan.
3. Wind down during the evening. Do not do anything mentally challenging within 90 minutes of bedtime, and stick to a routine.
4. Do not sleep or nap in the armchair. Keep sleep for bedtime.
5. Do not drink too much coffee or tea; eat a light snack for dinner and avoid eating chocolate and other products containing caffeine. Try to get used to de-caffeinated drinks.
6. Cut down your smoking in the evening and try not to smoke if you wake during the night.
7. Do not drink alcohol to aid your sleep – it usually upsets sleep.
8. Make sure your bed and bedroom are comfortable – not too cold, warm, noisy or bright. The room should be well aired and the alarm clock turned towards the wall.
9. Make preparations for waking during the night, such as leaving the heating on low in the living room and making a flask of a warm milky drink.

At bedtime

10. Stay out of bed until your threshold time and until you feel 'sleepy-tired' – a tiredness that will make you fall asleep quickly and take you through the night.
11. Once in bed switch the light off immediately.
12. Do not read, watch TV, speak on the telephone, eat, drink, etc. in bed. The bedroom is for sleeping only, with the exception of sexual activity.
13. Practice relaxation exercises, followed by your imagery story. These procedures should be practised in the daytime before you try to apply them at night.
14. Give up trying to sleep. Keep your eyes open and gently resist sleep, or adopt a carefree or accepting attitude to wakefulness.
15. Remind yourself that sleep will come naturally. Repeat steps 13 and 14 as required.
16. Have your alarm set for the same rising time every day, 7 days a week, and make sure you rise at this time.

If you can't sleep or if you wake

17. If you can't sleep within quarter-of-an-hour of putting the light out, get up and go into the living room.
18. Use the same rule in step 18 if you wake during the night and can't get back to sleep quickly.
19. Do something relaxing (planned beforehand) for a while when out of bed and do not worry about tomorrow.
20. Remind yourself that sleep problems are common and not as damaging as you think. Try to avoid getting upset or frustrated.
21. Challenge all other intrusive and inaccurate ideas and mental images. Evaluate them and try to

prevent them from dominating your thoughts.

22. Go back to bed when you feel 'sleepy-tired' again. Put the light out and relax.

23. Try to block out unwanted thoughts by repeating the word 'the' to yourself every 2 seconds. Try to keep this up for 5 minutes at a time.

24. Write down any intrusive thoughts or concerns in a notebook kept at your bedside and deal with them in the morning.

25. If you still can't sleep then get up again after quarter of an hour and repeat steps 19 to 24.

Table 15 Putting the CBT program into practice

Progress Record Date:

CBT components I am ACHIEVING	CBT components I am NOT ACHIEVING	CBT components NOT RELEVANT TO ME

Identifying and Monitoring Your Progress

I thought it might help if you had a table to summarize some of your Sleep Diary measures and how they have been changing over time. Have a look at Table 16 (pp. 168–9).

The first column is for your sleep as it was at the start. You can transfer that information from your very first Sleep Diary. The second column is for how your sleep is now; that is from your most recent diary. There are other columns that you can use in the future. In our research studies we do follow-ups at 1, 3, and 6 months; sometimes even at 12 months, after completion of CBT programs. By completing Table 16 you should be able to see the *relationship* between what you are doing in implementing the CBT program and your progress with your sleep.

Conducting this careful analysis of your sleep pattern and sleep quality will also help you see exactly where there has been some positive change, and exactly where there is still room for improvement. I would encourage you to use your notebook to write down some *maintenance goals* and some *improvement goals*.

Maintenance goals are your plans for keeping going with progress that has already taken place. For example, you might be falling asleep much more quickly now, so you want to make sure that you keep doing so. Your improvement goals would then be aspects of your sleep that still have some way to go. With the improvement goals, try to figure out how you can use the CBT program to help yourself. Write down in your notebook the conclusions you arrive at and the decisions you make about what to do. It may be that your record of putting CBT into practice (Table 15) will suggest things that need some extra work.

Trusting the Evidence

You are now gathering your own *personal evidence* about CBT for insomnia, but I just want to remind you that there is a lot of *scientific evidence* indicating that CBT is likely to work for you. We know from studies that people keep on improving for at least six months after starting programs like this. In one of the studies that we did in Scotland we found continued improvement even a year later. Every encouragement, then, to keep on going! You will get more and more used to changes that you have made and you will reap more benefits. You have done the hard part so don't give up now.

Making Lasting Changes

Remember we are in this for the long game. I want to help you achieve change that will last. Ideally it would be great if you transformed from a poor sleeper to a good sleeper.

We have been concentrating on examining changes that may be seen in your sleep pattern itself, but I hope there will be more than this for you. People I see at my sleep clinics often report benefits to their general well-being, not just to their sleep. This is because sleeping well is healthy, and brings with it important bonuses. Improvements in concentration, productivity, mood and quality of life are certainly possible over a period of months. In my experience these form part of the changes that can last. Have

a think about whether you are beginning to see any *generalized* benefits like these just now, and write these down in your diary.

You will encounter obstacles on the way, be sure of that. In my line of work we sometimes talk about something called *relapse-prevention*. Remember the wheel of motivation? It tells us that we should expect to slip at times, so it is best to be prepared for that. Sometime or other you will get some bad nights and you will worry that you are in danger of being back at 'square one'. Relapse-prevention tells you first to expect that to happen, and second to reinstate all the elements of the CBT program as soon as you can. If you feel that you are already doing these things and you can't understand why your sleep is disturbed, simply hold to your CBT course program, ride the storm, and it will probably rectify itself. Remember that acute sleep disturbance is essentially normal and temporary. It will tend to right itself as long as you don't get preoccupied with it.

Table 16 Evaluating progress using your Sleep Diary

Sleep Diary measure	Before CBT Date	Now Date	Follow-up Date	Follow-up Date	Follow-up Date
Wake-up time					
Rising time					
Bedtime					
Lights out					
Time in bed (lights out to rising time: mins)					
Time to fall asleep (mins)					
Number of awakenings					

Time awake during wakenings (mins) Total time slept (mins) Sleep efficiency (Total time slept/Time in bed \times 100) Sleeping pills (number or mg) Alcohol (units) Feeling rested after sleep 0, 1, 2, 3, or 4 Sleep quality rating 0, 1, 2, 3, or 4	

You can also use this book as a form of *booster therapy*. This is a term we use in practice to describe how it often helps to give our progress a boost from time to time by refreshing the program. Just because you have read right through now doesn't mean that you have necessarily got the full benefit. Re-reading helps. Come back to the book to give yourself booster sessions on a regular basis. Why not even write some dates down right now in your notebook or your diary as a commitment to carrying on with the CBT approach?

Finally, keep in mind that your sleep efficiency is the key. I would urge you to check your sleep efficiency each and every week, aiming for 90 per cent. Make adjustments to your sleep window, as you have learned to do, and I am sure you will find that your sleep pattern becomes more regular and more satisfying. Once this happens you will be able to sleep without consciously using the CBT techniques or methods. They will have become second nature to you, and you will be well on the way to becoming a good sleeper.

My very best wishes to you in overcoming your insomnia.

PART THREE

Special Circumstances

Introduction to Part Three

The final part of this book comprises two brief chapters. They are relevant to you in the special circumstances where you may need to consider what to do either about sleep medication, or about the possibility that you have a sleep disorder other than insomnia. Chapter 11 is about sleeping pills and Chapter 12 is about what clinicians call differential diagnosis.

What about Sleeping Pills?

Introduction

Although this book is about CBT, it is useful to include a brief chapter on sleeping pills. If you are taking medication for your insomnia, or are taking some other kind of medicine that affects your sleep, you must obtain advice from your prescribing doctor. I want to stress this point for two reasons. First, your doctor knows your overall physical and mental health and is best qualified to give advice about your medicine management. Second, the comments that I make here can only be taken as general in nature. They are *not* tailored to meet your particular individual needs. This chapter, therefore, should not be seen as an alternative to medical consultation.

Aim

The broad purpose of this chapter is *to assist you in considering what place sleeping pills have in your sleep-management plan.*

I Don't Believe in Taking Pills

Perhaps you have picked up this book because it is about CBT – which is a non-pharmacological approach to therapy. It may be that you are hoping to manage your sleep without using medication. Perhaps you prefer a non-drug approach to your health wherever that is possible.

Certainly, we live in an increasingly 'self-help' culture. If that means that people are becoming more and more interested in taking responsibility for their health, and for finding solutions to their health problems, then I think that is a very good thing. Indeed, I have written this book because I wanted to make available to people what I know to be an effective insomnia treatment.

However, I am not in any fundamental sense against a pharmacological approach. Rather, my standpoint is that there is ample sound scientific evidence for the effectiveness of CBT for *persistent insomnia*. By comparison, there is very little evidence to support the long-term use of sleeping pills for persistent insomnia. To me, this is a matter of *evidence-based clinical practice* and not a matter of principle or philosophy.

All the reviews of the evidence concerning sleeping pills come to the same

conclusion: sleeping pills are not recommended for persistent sleep problems. However, they may be effective for acute or short-term insomnia. Taking a sleeping pill for a few nights, or for a couple of weeks, or from time to time, can be helpful to improve sleep over the short term. As far as I am aware, there are no guidelines anywhere in the world that recommend taking sleeping pills for months or for years.

I Would Rather Not, But . . .

You may come to the matter of sleeping pills from the perspective that you would really rather not take sleeping pills, but that you have found that they have given you at least some relief from insomnia. Perhaps it is difficult not to take them, especially in the absence of any real alternative. Well hopefully, this CBT program will give you that alternative approach!

I have to acknowledge that it would be so much simpler if there was a sleeping pill that did the trick. CBT for insomnia involves quite a lot of hard work on your part . . . and it has taken me all of these pages to explain it to you! If the only instruction required was ‘Take this pill 30 minutes before bedtime,’ matters would be greatly simplified, and much less demanding for all concerned.

Do I Need to Stop?

I think a lot of people go to their doctor worried that, one of these days, he or she is going to refuse to prescribe any more sleeping pills. Certainly I can think of patients who have felt that they were in the ‘last-chance saloon’! They may have been told that they can have pills for one more month only, or have been advised to ‘make them last’. Patients commonly recognize that they have gone the full circle with medication, and have not found anything that really solves the problem. Yet, the prospect of stopping may be very daunting.

All of this just reflects reality. The truth is that pharmacological solutions to persistent insomnia are not available. Doctors are under quite a bit of pressure not to prescribe treatments unless they are known to be effective, or unless they are clearly benefiting the individual patient. This can lead to quite a bit of momentum from the doctor’s side to encourage you to stop. Of course, stopping is important to patients, too . . . and may well be part of your goal in following this CBT program. Indeed, often patients say to me that they would feel much better about themselves if they could get off their medication. It is a goal in its own right. So my answer to the question ‘Do I need to stop?’ would be to take the bull by the horns. Go along to your doctor and have an honest discussion about your use of sleep medications. Discuss the specific medication that you are taking and about the length of time you have been on it. Discuss the potential benefits of staying on the pills relative to the benefits, and the difficulties, of withdrawing. Discuss whether or not there are any other pharmacological options. I am sure you would have your doctor’s respect for doing this. I think decisions about medication should always be a *partnership* between patient and doctor. Ask your doctor if you can agree a joint plan, based upon what would be best for your health. That plan might well be a reduction schedule. You should also explain that you are following a structured CBT program, and describe a bit about the content of the program.

Can I Take Sleeping Pills and Use CBT?

Again this is a question that my patients raise. So, we should also consider the possibility that there may be some benefit associated with taking sleep medication as well as following the CBT program. This too is something you could discuss with your doctor.

After all, if medication affords some short-term benefit to sleep, and CBT is effective in the long term, would it not be possible to capitalize on a combined sleeping pill-plus-CBT approach? In many ways this is an attractive idea. It is also a very important research question, because in practice this combination is probably quite common. Unfortunately, however, we do not have enough data to give us a good answer to the question.

Only a couple of studies have been published on this so far. Results from this research reinforce the *importance of the CBT component* if people with insomnia are to obtain lasting benefit. As far as I can see from my reading there is no clear advantage for combining CBT with sleeping pills, except possibly in the first few weeks. There are also a couple of potential problems to look out for. One is that taking sleeping pills may reduce your attention to the CBT program, because taking pills is relatively easy by comparison. Another is that attributional problems can arise with combination therapies. You can never be sure what is causing any benefit that you experience. For example, you could (incorrectly) attribute treatment effects to the medication and so slacken off or even abandon some of the CBT methods. This would be likely to lead to a poor outcome because, of the two, CBT is the proven treatment. It could also lead in extreme cases to the development of dependency on medication.

How Can I Come Off Pills Safely?

If you have decided that you want to stop taking sleeping pills, then you must consult your doctor. However, I can provide you with some general guidelines on good practice for safe withdrawal.

Over a period of time of taking medication for sleep, your body becomes used to the drug's chemical properties and to the concentration levels of the drug in your bloodstream. This process is known as *tolerance*. It is because of the build-up of tolerance that you may have experienced having to take a higher dose of your sleep medication in order to get the same effect. The fact that your body may have become used to the medication is one reason why a *gradual reduction* is essential.

Of course, the concentration of a drug in our bloodstream is something that is constantly changing as our bodies metabolize (use up) the chemical components of the drug. Different drugs are metabolized at different rates, and to give an indication of the length of time it takes our bodies to clear a compound, we use the term *half-life*. Half-life is the time (in hours) it takes for components of the drug to reduce their concentration by 50 per cent. So-called 'short-acting' drugs reach their peak concentrations in the bloodstream quickly and are eliminated quickly, whereas 'long-acting' drugs are usually slower to act, but also take much longer to clear. I have provided in Table 17 (over the page) some information about the most commonly used sleep medications and their properties. I have given the generic names for the drug compounds in the table. It may be that you are prescribed medication under this

name; alternatively, you may have one of these medications under a trade or brand name. These trade names differ from country to country, so you should check on the bottle or pill box to find the generic name of your medication on the list.

The advantage of short-acting sleeping pills is that, being more rapidly eliminated from the body, they tend to have fewer *carry-over effects* into the next day. By comparison, long-acting sleeping pills can lead to carry-over morning drowsiness. Clearly such effects are unwanted and can be dangerous, posing for example the risk of accidents. Although short-acting drugs avoid this particular problem, they are on the other hand more prone to *withdrawal effects*, because of their rapid elimination from the blood chemistry. Longer-acting drugs are eliminated more slowly and have a less abrupt withdrawal profile. As you will see in Table 17 there are some sleeping pills which are ‘medium’ in their effects, which means that they may either offer the best of both worlds, or possibly some degree of problem in both respects! The main advantage afforded by the newer non-benzodiazepine hypnotics (those starting with the letter ‘Z’) is that they have been found to have fewer adverse effects upon the structure of sleep. That is, people may get a more natural sleep. They may also have a less severe withdrawal profile.

Table 17 Some commonly prescribed sleeping pills and their properties

Sleeping pill (generic name)	Normal dosage range (mg)	Half-life (hours)
Clonazepam	0.5–2	20–60
Estazolam	1–2	8–24
Flurazepam	15–30	48–100
Lorazepam	0.5–2	10– 20
Nitrazepam	5–10	16–18
Oxazepam	10–30	5–10
Quazepam	7.5–30	40–120
Temazepam	7.5–30	8–17
Triazolam	0.125–0.25	2–4
Zaleplon	5–10	1
Zolpidem	5–10	1.5–5
Zopiclone	3.75–7.5	4–6

No doubt you will have heard people talking about having a ‘fast metabolism’ or a ‘slow metabolism’. This reflects another important consideration. Medication should be prescribed and withdrawn *on an individual basis*. As a general rule, for example, older adults metabolize drugs more slowly and eliminate them more slowly, which means that older adults on certain medications are more likely to experience carry-over effects.

So I would stress that there is no absolute recommended withdrawal rate if you are planning to try to do without sleeping pills. You really need to consult your doctor. What I have done, though, is provide you in Box 13 (over the page) with a few pointers concerning a medication reduction schedule. It is particularly important that any withdrawal process should follow a gradual *tapering off*.

Can CBT Help Me Come Off Sleep Medication?

Sometimes people want to know if they can replace their sleep medication with CBT. They want to be able to trust another method, and hope that CBT may provide them

with that opportunity. I think that this is a realistic possibility, but you need to think through what is likely to be the most successful means to that end for you. There are basically three options. All this is assuming you are following a gradual tapering off under medical supervision.

The first option is to withdraw medication gradually before commencing CBT. I will call this the 'withdraw-before' method. The main advantage here is that you can see what your underlying sleep pattern is like before starting CBT. As long as you have finally come off your sleeping pills for a few weeks, the withdraw-before option allows you to get a proper baseline on your sleep. It may even be that you won't have to start CBT if your sleep improves spontaneously once the medication is withdrawn. This does happen in some cases. The disadvantage, of course, is that it may not be easy to discontinue sleeping pills without some other strategy already in place.

Box 13 General advice on sleeping pill withdrawal

1. Always consult your doctor when you are considering reducing or stopping sleep medication.
2. Obtain advice on a planned withdrawal schedule that suits your individual requirements. A suitable plan may require weeks or even months to complete. Typically you can expect to withdraw over an 8- to 10-week period.
3. Always reduce sleep medication by gradual tapering. Usually, small reductions in the medication dosage, or in the frequency of doses, will be advised by your doctor. Commonly reductions will be of around 25 per cent of the dosage, at intervals of one to two weeks.
4. Do not take additional medications or substitute medications unless they have been prescribed for you.
5. Tapering schedules should be reviewed weekly, or more frequently if you experience severe withdrawal effects.
6. Once you get down to the lowest prescribed dosage for each night, your doctor may recommend having 'drug holidays'. This is where you skip nights from taking this lowest dose, gradually skipping more and more nights until you stop altogether.
7. Keep a careful note (in your Sleep Diary and notebook) of your medication use, sleep pattern, and experiences associated with the withdrawal period.
8. Staying off sleeping pills can be difficult. Try to prevent relapse by identifying situations coming up that might tempt you to take medication, and use CBT instead.

The second option would be the 'withdraw-after' method. The advantage here is that you don't need to start with the challenge of doing without pills and can concentrate straight away on the CBT program. If you see that your sleep is improving then you may gain sufficient confidence in CBT to enable you to withdraw. The disadvantage, though, is that your sleep pattern is likely to get disrupted again once the withdrawal process begins, and this might be difficult to deal with if you have only recently begun to sleep better. You should not expect that using CBT will mean that you can bypass drug-withdrawal effects, although it may help you cope with them better.

The third option is the 'withdraw-during' method. This might seem like the best compromise. However, you should bear in mind the disadvantage that it may be quite difficult to figure out how changes in your sleep pattern relate to the two things (CBT, withdrawal) that are going on at the same time.

How do you choose between these options? My advice would be to follow the one you are most likely to be able to carry through in practice. In other words, be *pragmatic* about this. The most important thing is to be able to take advantage of what CBT can offer and to stop medication if it is not benefiting you. If you can withdraw before and let the effects wash out of your system first, then that is probably ideal, but as I said – be pragmatic about what you are likely to be able to achieve . . . and good luck!

Recognizing and Managing Other Common Sleep Disorders

Introduction

At various points throughout this book I have mentioned the importance of checking that you *do* have insomnia . . . and checking that you *do not* have a different type of sleep problem. It is also possible that you could have more than one sleep disorder, of course.

In Chapter 3 I introduced you to the sleep disorders, and in Chapter 5 I gave you some tools to help you assess your sleep pattern and sleep symptoms. Remember I spoke about ‘screening’ procedures? Well, let me now introduce another bit of jargon that we use in clinical practice.

Clinicians are trained in what is known as *differential diagnosis*. That is the skill of distinguishing one type of disorder from another. When you are unwell you usually seek advice at first from a general medical practitioner, who begins the process of differential diagnosis. If it is thought that you need more specialized investigation or assessment, you may be referred on to someone else for an opinion. These days, diagnostic and treatment skills are becoming increasingly specialized, in every area of medicine. Sleep is no exception, and we now have clinicians who are sleep specialists. Often these doctors are neurologists or pulmonologists (respiratory specialists). The specialization in insomnia management has become known as *behavioral sleep medicine* and most professionals in this area are clinical psychologists.

I am not suggesting that you should do your own differential diagnosis. On the other hand, I think it is very helpful for you to be well informed about the key symptoms of different types of sleep disorder, so that if you do need to consult a professional you can have a more informed discussion about things. In particular, this chapter should help raise your awareness about five different groups of sleep disorders which may need managing in different ways. If you think that any of these might apply to you, you should make an appointment to see your doctor.

Aim

The aim of this chapter, therefore, is *to assist you in considering the possibility that you may have a sleep disorder other than insomnia, and to take steps to seek*

appropriate help.

Disorders of the Body Clock (Circadian Disorders)

I am going to say a bit more about circadian disorders of sleep than about the other categories which follow because these disorders are more commonly confused with insomnia. You will see in Table 18 (pp. 186–7) that I have provided you with a list of all the sleep disorders that we need to try to rule out.

We learned earlier that some body-clock functions are age-related. For example, the sleep drive of young adults can remain strong at 7 a.m., compared to older adults where it begins to decline from about 5 a.m. Later life is also associated with increases in sleepiness in the middle part of the evening. Another factor may simply be individual differences. Some people, regardless of age, have always tended to be ‘larks’ and others have tended to be ‘owls’. So it is important that you consider both your age and your typical sleep time preferences before concluding that you have a circadian sleep disorder. In Table 18 there are two sub-categories of circadian problem that I want to mention. Let’s take each of these in turn.

Delayed sleep phase syndrome (DSPS) often develops at a young age. You may not be surprised when you consider the key symptoms. This circadian disorder may present as a sleep-onset insomnia – that is, difficulty getting off to sleep. Central to the complaint is an inability to get to sleep at the desired time . . . but there is also an inability to wake up at the desired time. In other words, the person with DSPS is out of step with the world by falling asleep late and waking and rising late. You might say ‘typical of a teenager’, but for the person with DSPS disorder this has not just been a temporary stage of growing up. Another feature is that there is usually little night-to-night variability in sleep pattern. The person with DSPS can, if left to their own schedule, have a normal sleep of good quality. They will fall asleep quickly (late on), sleep right through, and also ‘sleep in’! Nevertheless, the EEG sleep stage distribution of their sleep will be normal. Typically, if they try to get up at a more normal hour (say 7 a.m.) they will remain drowsy for some hours until their body clock reaches its wake time.

Another reason why DSPS might develop, and this also applies to other circadian problems, is when people have been *working shifts* and then try to get back into an 11 p.m.-to-7 a.m. sleep pattern. Usually people begin to adjust after a couple of weeks, but there are those who find this much harder. *Jet lag* is an even more common experience that is also usually temporary. Typically it takes anything from a few days to around ten days for your body clock to adjust to a different time zone. The bigger the time difference, the more adjustment needs to be made, of course. Nevertheless, it seems that people differ in their adaptability to these different types of circadian problem because adolescence, shiftwork, and international travel affect some people much more than others.

Advanced sleep phase syndrome (ASPS) is the opposite of DSPS. In ASPS problems are associated with early settling to bed and with early morning awakening. It is hard to ‘keep going’ during the evening because sleepiness kicks in early, and it is impossible to sustain sleep beyond 3 or 4 a.m., or even earlier in extreme cases. ASPS is also the opposite of DSPS because it is more common in older people. Furthermore, the fragmentation of sleep in later life may lead to daytime napping, and this can contribute further to an already compromised circadian routine.

Table 18 Sleep disorders other than insomnia: summary of symptoms

Type of sleep disorder	Symptoms
Circadian disorder	<p><i>Delayed sleep phase syndrome</i> – awake till late, difficulty initiating sleep, difficulty waking in morning, still sleepy if rising at normal rising time, sleep normally if you go to bed very late and rise very late</p> <p><i>Advanced sleep phase syndrome</i> – evening sleepiness, difficulty delaying sleep till normal bedtime, early morning waking, sleep normally if you go to bed very early and rise very early</p>
Sleep-related breathing disorder	<p><i>Obstructive sleep apnea</i> – loud snoring (in most cases), breathing pauses, fragmented sleep with micro-arousals, daytime sleepiness, sometimes flat/depressed, often overweight</p>
Restless legs and limb movements in sleep	<p><i>Periodic limb movement disorder</i> – involuntary jerky movements interrupting sleep, repetitive pattern of movements, may have daytime sleepiness</p> <p><i>Restless legs syndrome</i> – irresistible urge to move legs when at rest, causing arousals from sleep</p>
Parasomnias	<p><i>Sleepwalking</i> – occurs during incomplete arousals from deep sleep, difficult to waken, usually amnesic for event</p>

	<p><i>Sleeptalking</i> – normally occurs during transitions between sleep stages</p> <p><i>Night terrors</i> – often sit up in bed, strong emotional display, difficult to comfort or waken, usually amnesic for event</p> <p><i>Confusional arousals</i> – similar to sleepwalking, confused after waking</p> <p><i>Nightmares</i> – emotionally-laden dream content, often waken frightened from REM sleep</p> <p><i>Teeth-grinding (nocturnal bruxism)</i> – occurs in different stages of sleep and at transitions</p> <p><i>REM behavior disorder</i> – muscle tone retained during REM sleep, dream enactment often aggressive</p>
Narcolepsy and hypersomnia	<p>Full narcolepsy syndrome comprises:</p> <p><i>Sleep attacks</i> – sudden involuntary sleeps in the daytime</p> <p><i>Hypersomnia</i> – excessive sleepiness and extended sleeps</p> <p><i>Cataplexy</i> – sudden loss of muscle tone in major muscle groups, in response to emotion</p> <p><i>Hypnagogic/hypnopompic hallucinations</i> – dream-like hallucinations upon entering/leaving sleep</p> <p><i>Sleep paralysis</i> – inability to move voluntarily, especially when emerging from sleep</p>

I should point out that of course our lifestyle plays a part in determining circadian disorders of the DSPS and ASPS variety. I have already mentioned the ‘enforced’ lifestyle of shiftwork. *Lifestyle choices* may also be implicated in the development of sleep phase disorders. For example, retired people may choose to retire early to bed because their lifestyle does not necessitate staying up late for a whole variety of

reasons. In psychology we talk of *zeitgebers* or ‘time-givers’. These are the factors that determine the social rhythm of our lives – our routine. Developmental, social, and personal factors may all be *zeitgebers*. However, where sleep and wakefulness are concerned, natural light is the biggest *zeitgeber* of all. Generally speaking, we sleep when it is dark and we are awake in the daylight.

How can you know if you have circadian disorder rather than insomnia? Well, first of all consult the key symptom checklist in Table 18 (pp. 186–7). Also go back over the relevant part of the sleep history I gave you in Table 4 (pp. 68–70). Another thing you can do is to look through your Sleep Diaries. I suggest taking at least two consecutive weeks, and longer if you can. Do you find that you tend to go to bed early and to wake early? Do you sleep well if you allow yourself to follow that routine? If so, ASPS is worth considering. Do you find that you don’t properly wake up until hours after you rise in the morning? Do you find that you never get to sleep until the ‘small hours’? If so then you could have DSPS.

If you can get access to an actigraphic assessment of your sleep, this will help with diagnosis. An *actigraph* is a device worn like a wristwatch that measures body movement and stores the information in an internal microchip for computer analysis. Active and inactive periods across several weeks are then displayed graphically, and it is possible to see what times of the day and night the natural peaks and troughs in movement occur. If they are out of alignment with the normal sleep (inactive) and wake (active) cycles, then this might suggest that you have a circadian problem. We are moving here into specialized assessment, though. You can’t expect to get this kind of help from your local doctor. I would suggest that if you suspect DSPS or ASPS, you should take this thought to your doctor and consider with him or her what to do next. There are several options that might be considered.

Sometimes just *rescheduling* your sleep strictly, and gradually shifting your bedtime and rising time, can be effective. The aim is to move steadily closer and closer to the normal bedtime hours. For example, let’s suppose the problem is DSPS and you think that you are three hours out of line (getting sleepy at 2 a.m. and remaining sleepy till around 10 a.m.). You might start by sleeping 2–10 a.m. for one week, then shift to 1.45–9.45 a.m. in week two, then to 1.30–9.30 a.m. during week three, and so on, until you get to your desired schedule. If you had ASPS, you would reschedule too, but in the opposite direction of course!

There is also some evidence that oral *melatonin* supplementation can improve sleep timing, so it may be useful for DSPS and ASPS. The regulations surrounding the availability of melatonin vary from country to country. For example, in the USA melatonin can be purchased over the counter as a food supplement. In the UK it is available only on special prescription. Generally speaking, melatonin would be taken some hours before bed in DSPS and in the morning in ASPS. You will recall that the brain produces melatonin at night. Taking melatonin as a pill may be one way of enhancing sleep during the normal clock phase. Clearly you should follow the advice given by the manufacturer, by your pharmacist and by your doctor.

Finally, there is some evidence that *bright light therapy* can be used to improve circadian rhythm. This is connected to the melatonin story because, as we learned before, bright light shuts down the brain’s production of melatonin. In DSPS, bright light in the morning can help to advance the major sleep period, and in ASPS, bright light in the evening can help to delay sleep. Light boxes are commercially available in stores and on the web. If you want to use one of these you should again take care

to read the instructions and limitations carefully. The evidence seems to be that 10,000 lux for 30 minutes or lower levels for longer periods is required to have a therapeutic effect.

It may be possible to combine the use of rescheduling, melatonin, and light therapy. As with the diagnosis of DSPS or ASPS, the treatment of circadian disorders should be conducted under skilled supervision. Certainly consult your doctor and consider the possibility of referral to a specialized Sleep Disorders Clinic.

Sleep-Related Breathing Disorders (SBD)

This term refers to a group of disorders that seriously disrupt the continuity of sleep through impaired breathing. In some countries this field is known as *respiratory* medicine, in others the term *pulmonary* medicine is used. Either way, the point is that when breathing is affected during sleep, the quality of sleep that a person gets is likely to be poorer.

The most obvious and common example that comes to mind is *snoring*. Many people snore. This does not mean that they necessarily have a clinical problem with their sleep. Snoring is simply the sound made by the passage of air across a restricted airway. During sleep there is a tendency for the airway to ‘collapse’ (get narrower) so there is more respiratory effort involved in drawing air through the nose. Of course air contains the *oxygen* that sustains life, so as long as the brain can tell that we are getting enough oxygen into the bloodstream there is no problem – except perhaps for our partner having to listen to the noise!

However, if there is not enough air getting through, the bloodstream becomes *deoxygenated* or *desaturated*. Fortunately, the brain ‘reads’ this situation and causes us to arouse from sleep towards wakefulness, so that more normal breathing can recommence. It is also possible for people who do not snore to have respiratory problems of this kind, but snoring, being overweight and having a thick-set neck (with a collar size of 17 inches or more) are all closely related to sleep-related breathing disorders. SBDs are present in 2 per cent of men between the ages of 30 and 65, and in 1 per cent of women of the same age.

There is increasing public awareness of an SBD known as *obstructive sleep apnea* (OSA). In OSA, the upper airway collapses primarily during Stages 1 and 2 of sleep – that is, the lighter forms of non-REM sleep. An apnea is a complete closure/blockage of the upper airway. Basically, breathing stops. Partial, or incomplete, closures may also occur; these are known as hypopneas. In OSA apneic and hypopneic events disrupt sleep by causing *micro-arousals*. These brief awakenings are enough to cause *sleep fragmentation* and to decrease periods of Stage 3 and 4 and REM sleep.

How would you know if you have an SBD? Well, your most obvious night-time symptom would be difficulty remaining asleep. You might even be conscious of a tendency to wake out of sleep catching your breath, or of a feeling that you had stopped breathing. Some people wake themselves up with the sudden re-starting of their breathing after an apnea. Also, speak to your partner, who may be more aware of your breathing pattern or your snoring, and may have witnessed these ‘breathing pauses’. Sometimes people with OSA wake with a headache and a very dry mouth in the morning.

OSA is associated also with daytime symptoms. The most important of these is

excessive daytime sleepiness. Here there may be an involuntary tendency to fall asleep when at rest, or even when undertaking activities. Problems with concentration and irritability are often reported in OSA, and sleepiness has been linked to an increased likelihood of road traffic and industrial accidents. This is not a disorder to be taken lightly, because you and others can be at risk due to sleepiness. SBDs have also been associated with an increased risk of medical disorders, particularly of the cardiovascular system.

Clinical diagnosis of an SBD can only be confirmed through PSG assessment. These assessments include not only the standard sleep set-up (EEG, EOG, EMG) but also measurement of respiration and of blood-oxygen saturation levels. Of course assessment would also include a detailed interview, and partners are often invited to attend, for the reasons mentioned above. If you suspect that you may have an SBD, you should consult your doctor. Certainly if you have daytime sleepiness problems there is a distinct possibility that your sleep at night needs some investigation. Your doctor will know where to refer you.

Regarding treatment, *positional advice* to maximize breathing and to prevent airway collapse, and *weight loss* may be beneficial. Some dental *prosthetic devices* are also available. These are normally ‘made to measure’ and are worn in the mouth to improve breathing during sleep. Most of these devices serve to advance the lower jaw and extend the airway. *Surgery* is also used in some severe cases of OSA to rectify problems more permanently. At the symptomatic level, some *medications* that stimulate arousal and reduce daytime sleepiness may also help more mild to moderate cases.

The mainstay of treatment for OSA, however, is known as *continuous positive airway pressure* (CPAP). This is a simple mechanical pump which delivers a steady stream of air during sleep. This air is delivered under sufficient pressure to support the upper airway and to preventing collapse. Unfortunately, CPAP is not an elegant treatment. The most common clinical practice is to recommend use of a special mask that fits over the nose and is held in place by headgear consisting of straps. The mask is connected to a flexible tube through which air is delivered from the pump machine.

The good news is that CPAP is very effective at eliminating breathing pauses. This restores the natural pattern of sleep without interruption, and daytime symptoms reduce markedly. Normally people need to keep on using their CPAP machine long term if they want to stay symptom free.

Restless Legs and Limb Movements in Sleep

Periodic limb movement disorder (PLMD) and *restless legs syndrome* (RLS) are disorders that may occur in people who have SBD, or may exist even where there are no breathing disorders. Again there are no psychological treatments for PLMD or RLS; both conditions require careful assessment.

PLMD is mainly associated with older age, and involves muscle twitches in the limbs, particularly the legs, during sleep. These episodes of involuntary movement disrupt sleep, causing arousals from sleep Stages 1 and 2, leading to complaints of daytime sleepiness and insomnia. The diagnosis of PLMD must be confirmed by PSG showing that jerky leg movements are directly related to brief sleep arousals.

Most people have experienced the occasional involuntary limb movement. For example, many people get what we call *hypnic jerks* or *sleep starts* from time to time.

These are sudden, brief jerky movements that occur at or around sleep-onset and wake us from light sleep. Hypnic jerks sometimes become a problem in their own right, but for most people they happen rarely. In some ways the movements in PLMD are similar to this, except they occur repeatedly and throughout the night.

We do not know exactly why people get PLMD. It may be related to disturbance of circadian sleep–wake rhythms in later life or to specific disorders of motor function that, again, occur more commonly in older adults. However, there are some medications that help PLMD. The options are either sedative-type drugs of the benzodiazepine family that reduce muscle function during sleep, or dopaminergic agents that are used to treat neuromuscular disorders.

RLS, as the name suggests, involves periods of irresistible urges to move the legs. These episodes are associated with unpleasant cramping sensations in the legs that are relieved only by walking or other movement or exercising of the legs. The symptoms begin mostly in the evening, potentially delaying the onset of sleep. So, they may occur when a person is resting or relaxing, and not only during sleep itself. When they interfere with sleep the usual result is sleep fragmentation and arousals. However, the relationship between RLS and daytime sleepiness is not clearly established. Normally people with RLS are able to give a clear picture of their problem, and they may have had it a long time. Although many people with RLS are of middle-age or older, about one-third of cases have their first symptoms before the age of 20.

The background to RLS is also a bit of a mystery, but like PLMD there may be associated changes in dopamine neuro-transmission. Some of these may be age-related. RLS has also been associated with pregnancy and with end-stage renal (kidney) disease. Treatment of RLS is similar to that for PLMD, and indeed the two commonly go together. Some people with RLS are also given iron supplements.

Sleepwalking, Night Terrors, and Other Parasomnias

The *parasomnias* are a group of disorders that intrude into the sleep process and create disruptive behavioral events. They are associated with disorders of arousal, of partial arousal, or of transitions between different stages of sleep. Non-REM parasomnias are quite common during childhood, and in most instances resolve quite naturally. However, they can also persist into adulthood or, less commonly, begin then for the first time. The most common presentations of parasomnia include *sleepwalking (sommambulism)*, *sleepwalking (sommiloquy)*, *night terrors* (sometimes called *sleep terrors*), and disorientation or confusion upon waking (*confusional arousals*). These constitute primary parasomnias, and are disorders of arousal.

Other primary parasomnias include REM sleep disorders, such as *REM behavior disorder (RBD)*. This is characterized by an absence of the muscle atonia that is normally present during REM sleep. In other words, someone with RBD may have retained motor function during dreaming sleep. So the person with RBD may be able to act out their dreams, carrying out complex and seemingly purposeful behavior while remaining physiologically asleep. Consequently, primary parasomnias and their associated behaviors – particularly sleepwalking and dream enactment – may lead to personal injury or injury to a bed partner. On rare occasions people have been known to carry out relatively complex tasks, like driving a car, during a parasomnia episode.

Precisely when these events occur during the night is often crucial in determining the underlying sleep disorder. For example, night terrors occur in Stage 3 or 4 sleep, often towards the end of the first or second phase of deep sleep. Therefore, like sleepwalking, they occur more commonly during the first third of the night. Because incomplete arousals out of deep sleep are involved, people who sleepwalk or have night terrors rarely have any accurate recall of what they were doing or what was on their mind at the time. This may seem surprising to the observer because the sleepwalker may appear purposeful in their activity, perhaps even trying to get out of the house or to find something. Similarly, a night terror is very distressing to watch because the person experiencing it appears extremely emotional and in a state of high physiological arousal and agitation. It is because the arousal is not a complete one and because the stage of sleep is a deep one that there is no conscious memory trace. Even if you do wake a sleepwalker or rouse someone from a night terror, they tend to remain 'groggy' and have only fleeting images or emotional statements to report.

By contrast, *nightmares* occur during REM sleep, which is, as we have learned, a relatively light form of sleep. They also relate more to the second half of the night, when REM episodes are more prolonged. These events often end with the dreamer actually waking up, so the memory trace is laid down more vividly. Indeed, because nightmares usually involve frightening or bizarre images, arousal from sleep is not only abrupt but lucid, and the person is unable to get back to sleep easily. Experts use the term *narrative recall* to describe the sleeper's ability to recount the occurrence and content of these dream events. The storyline is retained, and can sometimes be recurrent.

Having a better understanding of what is going on is the best treatment for all the parasomnias. *Information, education, and reassurance* are very important. Indeed, I quite often find that once I have explained the symptoms and given the diagnosis, patients with these problems may not need to come back to the clinic. We usually discover that there is an early history of, say, being prone to sleepwalking, and that some current stress factor has brought about a recurrence. Sometimes, though, people haven't acknowledged that they are under a strain – so be warned! On occasions I say to people that their parasomnia is 'like a friend tapping them on the shoulder and asking if they are sure they are OK'. So if you are the kind of person who copes with things very well on the surface, but tend to bury things you don't like to face, or if you bottle them up – then you will know I am speaking to you. Examining your individual *coping style* can be useful here.

Other things can make parasomnias more of a problem. *Sleep deprivation* is to be avoided, because if you are not getting enough sleep, the homeostatic pressure for sleep builds up. Too many late nights, particularly when accompanied by a change in life circumstances, can be fertile ground for parasomnias to arise. You see, in these circumstances your deep sleep and your REM sleep, the two most important sleep types, can go into 'rebound' – that is, you need more of them as your body tries to catch up on lost sleep. Consequently the likelihood of parasomnia increases because you spend more time in the sleep states that play host to parasomnia problems.

A related risk factor is *alcohol*, because alcohol also plays around with the natural proportions of our night's sleep. You can certainly be more prone to parasomnias after drinking, so I advise people who have problems with parasomnias to drink in very careful moderation, if at all. You will realize, too, that these risk factors can converge when you are staying up late, drinking, out of your usual routines and

trying to deal with stressful problems all at once.

I also want to mention *safety* and what might be called *risk assessment*. If you get out of bed and you are not properly awake, then you are potentially at greater risk of injury. I mentioned before that some sleepwalkers try to go outdoors, even through windows. Some people can be more likely to sleepwalk in unfamiliar places, which of course carries its own risks. It is important, therefore, that you consider potential risk factors and address these with your family or the people you live with.

Before leaving this section I want to return briefly to RBD. This is most common in middle-aged or older men. It can occur on its own, or it can be associated with motor disorders that occur mainly later on in life, such as Parkinson's disease. It can also be caused or made worse by some medications. So these things should be checked out with your doctor. In RBD it is quite common for a bed partner to get injured during the enactment of the sleeper's dreams, and this is the most frequent trigger to help-seeking, in my experience. Once again, all the components of management that I have already mentioned are important with RBD, plus a diagnostic PSG assessment if you and your doctor feel that this is necessary. There are some drugs that can help reduce or eliminate the symptoms of RBD.

Narcolepsy and Hypersomnia

There are a number of key characteristic symptoms associated with *narcolepsy*. Some of these relate to the sleep period and some to daytime. *Hypersomnia* is a term we use for excessive sleepiness, and it can occur without all the symptoms of the full narcolepsy syndrome.

Narcolepsy causes extreme daytime sleepiness, which can lead to a *sleep attack*. Normally we fall asleep gradually and we notice the increasing signs of drowsiness along the way. People with narcolepsy can sometimes be aware of their sleepiness, which is very extreme, but they also have sudden sleep attacks that come on more or less out of the blue. Another daytime symptom is called *cataplexy*. This can also occur very suddenly in the form of a cataplectic attack when the body muscles give way, often triggered by extremes of emotion such as humour or anger.

At night, narcolepsy is associated with abnormalities of REM sleep. *Hypnagogic hallucinations* are vivid, dreamlike experiences that occur around sleep-onset, and *hypnopompic hallucinations* are similar phenomena that arise in the morning upon waking. People with narcolepsy go into REM sleep quite readily and so they can experience these transitional dream experiences as if they were part of normal consciousness.

There is another unusual symptom known as *sleep paralysis*. This is a period of inability to perform voluntary movements either at sleep-onset or upon waking. In simple terms, the mind wakes up but the body remains paralysed. So you will see that narcolepsy is a strange disorder with a number of quite frightening symptoms.

In recent years genetic markers for this disorder have been identified, and this has improved the accuracy of narcolepsy diagnoses. Diagnosis can only be fully determined, however, through full PSG assessment and a procedure known as a *multiple sleep latency test* (MSLT). The MSLT involves attending a sleep laboratory and being given successive 'sleep opportunities' across a period of time. The goal is to detect how rapidly sleep occurs, and to explore the sleep-stage characteristics of the sleep that is observed. The possibility of *rapid-onset REM sleep* is one of the

features that is being investigated in an MSLT, because this is common in narcolepsy but rare in normal sleepers.

Effective pharmacological treatments have been developed for narcolepsy. These are mostly *stimulant drugs* to help sustain wakeful brain function. Although these drugs are effective, they treat only the symptoms. Addressing *behavioral factors* such as maintaining a stable sleep pattern, avoiding sleep deprivation, and taking scheduled daytime naps also helps.

Further Help

We started in Part Two with the idea of screening for the possibility that you may have a sleep problem other than insomnia. You have now read this additional chapter to help you to clarify that possibility. I hope that you are now a bit further on in your own thinking on the matter. Your next step should be to make an appointment to see your doctor. Take your new found knowledge, your thoughts, and concerns with you to that appointment. You can then discuss the possibility of referral to a specialist sleep clinic if that seems to be the best way forward.

Glossary

actigraph a simple device, usually worn on the wrist, that measures body movement and provides an estimate of time spent awake and time spent asleep.

advanced sleep phase syndrome (ASPS) a circadian disorder of sleep where the 'body clock' is set to fall asleep early and to wake early.

attention bias a tendency to selectively focus, to find your attention drawn to something. In the case of insomnia the focus is upon sleep and wakefulness.

attention–intention–effort an insomnia process where attention bias leads to intentional sleep and then to effortful sleep, all of which cause wakefulness.

attributions the beliefs that people hold about the causes of a problem.

automaticity the natural and involuntary process of sleep in good sleepers. This is disrupted by attention–intention–effort in insomnia.

circadian rhythm the regular sleep–wake cycle that is determined by a 'body clock' mechanism in the brain.

delayed sleep phase syndrome (DSPS) a circadian disorder of sleep where the body clock is set to fall asleep late and to wake late.

Diagnostic and Statistical Manual of Mental Disorders (DSM) a schedule used by mental health professionals to diagnose mental health problems.

electroencephalography (EEG) the measurement of electrical activity in the brain from scalp electrodes.

electromyography (EMG) the measurement of muscle activity using electrodes attached to the body (commonly to the chin and legs).

electro-oculography (EOG) the measurement of eye movements using electrodes attached at the side of the eye sockets.

hypnogram a graphical presentation of sleep showing transitions between sleep stages in fine detail across the night.

International Classification of Sleep Disorders (ICSD) a schedule used by sleep experts to diagnose different sleep disorders.

melatonin a naturally occurring brain hormone that helps to regulate circadian rhythm.

multiple sleep latency test (MSLT) a test of daytime sleepiness that indicates how sleep deprived a person is.

narcolepsy a sleep disorder characterized by excessive sleepiness, sleep attacks, and a number of specific features.

non-REM sleep sleep stages 1, 2, 3 and 4 form 75 per cent of the night's sleep, with Stage 2 being the most common.

obstructive sleep apnea a sleep-related breathing disorder involving breathing pauses during sleep that make people excessively sleepy during the daytime.

paradoxical insomnia a complaint of insomnia whereby people feel that they hardly ever sleep at all; formerly known as sleep state misperception.

parasomnias a group of sleep disorders characterized by nocturnal activity during partial arousals from sleep or transitions between sleep stages. The most common non-REM parasomnias are sleepwalking, sleep talking, and night terrors. The most common REM parasomnias are nightmares.

periodic limb movement disorder (PLMD) periodic limb movements during sleep involving repetitive jerky movements. They can constitute a disorder when they disrupt sleep.

polysomnography (PSG) the detailed measurement of the sleep process using many (poly) measurements including EEG, EMG and EOG. PSGs are usually conducted in a lab, but there are portable systems for home use.

primary insomnia a primary insomnia is a disorder of sleep in its own right, not caused by some other known factor such as a medical condition.

psychophysiologic insomnia a primary insomnia caused largely by psychological factors including conditioned arousal in bed and sleep-related worry. See also attention–intention– effort.

randomized controlled trial (RCT) a scientific study that tests the effectiveness of a treatment under controlled conditions, taking account of chance and often also of placebo factors.

rapid eye movement sleep (REM sleep) periods of sleep when the body is very still but the brain is very active (often dreaming). Named after its characteristic eye movements.

rebound insomnia an insomnia caused by withdrawal effects from drugs of a sedative nature.

restless legs syndrome (RLS) a sleep disorder characterized by unpleasant sensations in the legs, relieved only by movement.

secondary insomnia an insomnia associated with, or caused by, a medical or psychiatric disorder.

sleep deprivation the consequences of insufficient sleep involving fatigue, daytime sleepiness, and increased drive for recovery sleep.

sleep efficiency (SE) the proportion of time in bed that is spent asleep, expressed as a percentage.

sleep homeostasis the drive for sleep that is governed primarily by the amount of time spent awake. The homeostat tries to create a balance by satisfying sleep needs.

sleep stages sleep is divided into different stages (non-REM stages 1 to 4, REM sleep, wake and movement time) using standard scoring criteria.

sleep-onset latency (SOL) time taken to fall asleep after going to bed and putting out the light.

sleep state misperception former term for paradoxical insomnia.

time in bed (TIB) the period from retiring to rising.

total sleep time (TST) hours and minutes of sleep on a given night.

total wake time (TWT) the total of SOL plus WASO.

wake time after sleep-onset (WASO) the total time spent awake during night-time awakenings (after first falling asleep).

Useful Information

For information on psychotherapies and CBT

Association for Advancement of Behavior Therapy (AABT)

305 Seventh Avenue

16th Floor

New York

New York 10001-6008

USA

Tel: (001) 212 647 1890

Fax: (001) 212 647 1865

Web site: www.aabt.org

British Association for Behavioural and Cognitive Psychotherapies (BABCP)

The Globe Centre

PO Box 9

Accrington

BB5 0XB

Tel: 01254 875 277

Fax: 01254 239 114

Email: babcp@babcp.com

Web site: www.babcp.org.uk

The European Association for Behavioural and Cognitive Therapies (EABCT)

Email: eabct@vgct.nl

Web site: www.eabct.com

For information on insomnia and sleep problems

American Academy of Sleep Medicine

1 Westbrook Corporate Center Suite 920

Westchester

Illinois 60154

USA

Tel: (001) 708 492 0930

Fax: (001) 708 492 0943

Web site: www.aasmnet.org

Australasian Sleep Association

GPO Box 295

Sydney

NSW 1043

Australia

Tel: (0061) 0500 500 701

Fax: (0061) 0500 500 702

Email: sleepaus@ozemail.com.au

Web site: www.sleepaus.on.net

British Sleep Society

PO Box 247

Colne

Huntingdon

PE28 3UZ

Email: enquiries@sleeping.org.uk

Web site: www.sleeping.org.uk

Canadian Sleep Society (CSS)

Hôpital du Sacré-Coeur de Montréal

Centre de Recherche, 3K

5400, boul. Gouin Ouest

Montréal

QC H4J 1C4

Canada

Web site: www.css.to

European Sleep Research Society (ESRS)

Sleep Disorders Unit

Department of Neurology

Fundación Jiménez Díaz

Avda. de los Reyes Católicos, 2

28040 Madrid

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Tel: (0034) 91 543 1423 or (0034) 91 550 4927

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Web site: www.esrs.org

National Sleep Foundation (NSF)

1522 K Street NW

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Fax: (001) 202 347 3472

Email: nsf@sleepfoundation.org

Web site: www.sleepfoundation.org

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OVERCOMING LOW SELF-ESTEEM

*A self-help guide using
Cognitive Behavioral Techniques*

MELANIE J. V. FENNELL

Robinson
LONDON

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Foreword

Why cognitive behavior therapy?

Over the past two or three decades, there has been something of a revolution in the field of psychological treatment. Freud and his followers had a major impact on the way in which psychological therapy was conceptualized, and psychoanalysis and psychodynamic psychotherapy dominated the field for the first half of this century. So, long-term treatments were offered which were designed to uncover the childhood roots of personal problems – offered, that is, to those who could afford it. There was some attempt by a few health service practitioners with a public conscience to modify this form of treatment (by, for example, offering short-term treatment or group therapy), but the demand for help was so great that this had little impact. Also, whilst numerous case histories can be found of people who are convinced that psychotherapy did help them, practitioners of this form of therapy showed remarkably little interest in demonstrating that what they were offering their patients was, in fact, helpful.

As a reaction to the exclusivity of psychodynamic therapies and the slender evidence for their usefulness, in the 1950s and 1960s a set of techniques was developed, broadly collectively termed ‘behavior therapy’. These techniques shared two basic features. First, they aimed to remove symptoms (such as anxiety) by dealing with those symptoms themselves, rather than their deep-seated underlying historical causes. Second, they were techniques, loosely related to what laboratory psychologists were finding out about the mechanisms of learning, which were formulated in testable terms. Indeed, practitioners of behavior therapy were committed to using techniques of proven value or, at worst, of a form which could potentially be put to the test. The area where these techniques proved of most value was in the treatment of anxiety disorders, especially specific phobias (such as fear of animals or of heights) and agoraphobia, both notoriously difficult to treat using conventional psychotherapies.

After an initial flush of enthusiasm, discontent with behavior therapy grew. There were a number of reasons for this, an important one of which was the fact that behavior therapy did not deal with the internal thoughts which were so obviously central to the distress that patients were experiencing. In this context, the fact that behavior therapy proved so inadequate when it came to the treatment of depression highlighted the need for major revision. In the late 1960s and early 1970s a treatment was developed specifically for depression called ‘cognitive therapy’. The pioneer in this enterprise was an American psychiatrist, Professor Aaron T. Beck, who developed a theory of depression which emphasized the importance of people’s depressed styles of thinking. He also specified a new form of therapy. It would not be an exaggeration to say that Beck’s work has changed the nature of psychotherapy, not just for depressions but for a range of psychological problems.

In recent years the cognitive techniques introduced by Beck have been merged with the techniques developed earlier by the behavior therapists to produce a body of theory and practice which has come to be known as 'cognitive behavior therapy'. There are two reasons why this form of treatment has come to be so important within the field of psychotherapy. First, cognitive therapy for depression, as originally described by Beck and developed by his successors, has been subjected to the strictest scientific testing; and it has been found to be a highly successful treatment for a significant proportion of cases of depression. Not only has it proved to be as effective as the best alternative treatments (except in the most severe cases, where medication is required), but some studies suggest that people treated successfully with cognitive behavior therapy are less likely to experience a later recurrence of their depression than people treated successfully with other forms of therapy (such as antidepressant medication). Second, it has become clear that specific patterns of thinking are associated with a range of psychological problems and that treatments which deal with these styles of thinking are highly effective. So, specific cognitive behavioral treatments have been developed for anxiety disorders, like panic disorder, generalized anxiety disorder, specific phobias and social phobia, obsessive compulsive disorders, and hypochondriasis (health anxiety), as well as for other conditions such as compulsive gambling, alcohol and drug addiction, and eating disorders like bulimia nervosa and binge-eating disorder. Indeed, cognitive behavioral techniques have a wide application beyond the narrow categories of psychological disorders: they have been applied effectively, for example, to helping people with low self-esteem and those with marital difficulties.

At any one time almost 10 per cent of the general population is suffering from depression, and more than 10 per cent has one or other of the anxiety disorders. Many others have a range of psychological problems and personal difficulties. It is of the greatest importance that treatments of proven effectiveness are developed. However, even when the armoury of therapies is, as it were, full, there remains a very great problem – namely that the delivery of treatment is expensive and the resources are not going to be available evermore. Whilst this shortfall could be met by lots of people helping themselves, commonly the natural inclination to make oneself feel better in the present is to do precisely those things which perpetuate or even exacerbate one's problems. For example, the person with agoraphobia will stay at home to prevent the possibility of an anxiety attack; and the person with bulimia nervosa will avoid eating all potentially fattening foods. Whilst such strategies might resolve some immediate crisis, they leave the underlying problem intact and provide no real help in dealing with future difficulties.

So, there is a twin problem here: although effective treatments have been developed, they are not widely available; and when people try to help themselves they often make matters worse. In recent years the community of cognitive behavior therapists has responded to this situation. What they have done is to take the principles and techniques of specific cognitive behavior therapies for particular problems and represent them in self-help manuals. These manuals specify a systematic program of treatment which the individual sufferer is advised to work through to overcome their difficulties. In this way, the cognitive behavioral therapeutic techniques of proven value are being made available on the widest possible basis.

Self-help manuals are never going to replace therapists. Many people will need

individual treatment from a qualified therapist. It is also the case that, despite the widespread success of cognitive behavioral therapy, some people will not respond to it and will need one of the other treatments available. Nevertheless, although research on the use of cognitive behavioral self-help manuals is at an early stage, the work done to date indicates that for a very great many people such a manual will prove sufficient for them to overcome their problems without professional help.

Many people suffer silently and secretly for years. Sometimes appropriate help is not forthcoming despite their efforts to find it. Sometimes they feel too ashamed or guilty to reveal their problems to anyone. For many of these people the cognitive behavioral self-help manuals will provide a lifeline to recovery and a better future.

Professor Peter Cooper
The University of Reading

PART ONE

What is Low Self-Esteem? An Introduction to This Book

What is low self-esteem?

What do we mean by 'low self-esteem'?

Self-image
Self-concept
Self-perception
Self-confidence
Self-efficacy
Self-acceptance
Self-respect
Self-worth
Self-esteem

All these words refer to aspects of the way we view ourselves, the thoughts we have about ourselves, and the value we place on ourselves as people. Each has slightly different shades of meaning.

'Self-image', 'self-concept' and 'self-perception' all refer to the overall picture a person has of him- or herself. These terms do not necessarily imply any judgment or evaluation of the self, but simply describe a whole range of characteristics. For example:

- National, and perhaps regional, identity (e.g. 'I am English', 'I come from New York')
- Racial and cultural identity (e.g. 'I am black', 'I am Jewish')
- Social and professional role (e.g. 'I am a mother', 'I am a policeman')
- Life stage (e.g. 'I am just thirteen', 'I am a grandparent')
- Physical appearance (e.g. 'I am tall', 'I have brown eyes')
- Likes and dislikes (e.g. 'I love football', 'I can't stand spinach')
- Regular activities (e.g. 'I play baseball', 'I use a computer')

and

- Psychological qualities (e.g. 'I have a sense of humour', 'I lose my temper easily')

'Self-confidence' and 'self-efficacy', on the other hand, refer to our sense that we can do things successfully, and perhaps to a particular standard. As one self-confident person put it, 'I can do things and I know I can do things'. For example:

- Specific competencies (e.g. 'I am good at math', 'I can catch a ball')
- Social relationships (e.g. 'When I meet new people, on the whole I get on well with them', 'I am a good listener')

- General coping ability (e.g. 'If I set out to get something, I usually get it', 'I am a good person to turn to in a crisis')

'Self-acceptance', 'self-respect', 'self-worth' and 'self-esteem' introduce a different element. They do not simply refer to qualities we assign to ourselves, whether good or bad. Nor do they simply reflect things we believe we can or cannot do. Rather, they reflect the overall opinion we have of ourselves and the value we place on ourselves as people. Their tone may be positive (e.g. 'I am good', 'I am worthwhile') or negative (e.g. 'I am bad', 'I am useless'). When the tone is negative, we are talking about low self-esteem.

How do I know whether I have low self-esteem?

Take a look at the ten questions below. Put a tick next to each question, in the column that best reflects how you feel about yourself. Be honest – there are no right or wrong answers here, simply the truth about how you see yourself.

	Yes, definitely	Yes, mostly	Yes, some- times	No, mostly	No, not at all
My experience in life has taught me to value and appreciate myself					
I have a good opinion of myself					
I treat myself well and look after myself properly					
I like myself					
I give as much weight to my qualities, skills, assets and strengths as I do to my weaknesses and flaws					
I feel good about myself					
I feel I am entitled to other people's attention and time					
I believe I am entitled to the good things in life					
My expectations of myself are no more rigid or exacting than my expectations of other people					
I am kind and encouraging towards myself, rather than self-critical					

If your answers to these questions are anything other than 'Yes, definitely', then this book could be useful to you. If you are generally comfortable in accepting yourself as you are, if you have no real difficulty in respecting and appreciating yourself, if you see yourself as having intrinsic value and worth despite your human weaknesses, and feel entitled to take up your space in the world and to enjoy its riches, then you have the gift of self-esteem. You may still find ideas in this book that will interest you or open up avenues that you have not previously thought of, but any changes you make

will be built on the solid foundation of a broadly positive view of yourself. If, on the other hand, you feel your true self to be weak, inadequate, inferior or lacking in some way, if you are troubled by uncertainty and self-doubt, if your thoughts about yourself are often unkind and critical, or if you have difficulty in feeling that you have any true worth or entitlement to the good things in life, these are signs that your self-esteem is low. And low self-esteem may be having a painful and damaging effect on your life.

The impact of low self-esteem

‘Self-esteem’, then, refers to the overall opinion we have of ourselves, how we judge or evaluate ourselves, and the value we attach to ourselves as people. We will now consider in more detail the kind of impact low self-esteem can have on a person’s life. This will give you an opportunity to reflect on your own opinion of yourself, and what sort of value you place on yourself, as well as considering how your opinion of yourself affects your thoughts and feelings and how you operate on a day-to-day basis.

The essence of low self-esteem: Your central beliefs about yourself

At the heart of self-esteem lie your central beliefs about yourself and your core ideas about the kind of person you are. These beliefs normally have the appearance of statements of fact. They may seem straightforward reflections of your identity, pure statements of the truth about yourself. Actually, however, they are more likely to be opinions than facts – summary statements or conclusions you have come to about yourself, based on the experiences you have had in your life, and in particular the messages you have received about the kind of person you are. So, to put it simply, if your experiences have generally been positive, your beliefs about yourself are likely to be equally positive. If your experiences have been pretty mixed (as most people’s are), then you may have a range of different ideas about yourself, and apply them flexibly according to the circumstances in which you find yourself. However, if your experiences have been generally negative, then your beliefs about yourself are likely to be equally negative. Negative beliefs about yourself constitute the essence of low self-esteem. And this essence may have coloured and contaminated many aspects of your life.

The impact of low self-esteem on the person

Negative beliefs about the self – which form the essence of low self-esteem – express themselves in many ways.

To get a sense of this, it may be useful to think about someone you know who you would say had low self-esteem. If you think you have low self-esteem, you could of course consider yourself at this point. But you may find it more helpful first of all to consider another person instead. This is because, if you try to look at yourself, it is often difficult to obtain a clear view – you are too close to the problem. Think now about the person you have chosen. Remember recent times when you have met. What happened? What did you talk about? How did your person look? What did they do? How did you feel with them? Try to get a really clear picture of them in your mind’s

eye. Now the question is: how do you know that this person has low self-esteem? What is about them that tells you they have a problem in this area?

Jot down as many things as you can think of that give the game away. Look for clues in what your person says. For example, do you hear a lot of self-criticism, or apologies? What does this tell you about how your person thinks about him- or herself? Look at what your person does, including how he or she gets along with you and other people. For example, is he or she characteristically quiet and shy in company? Or conversely always rather pushy and self-promoting? What does this tell you? And what about self-presentation (posture, facial expression, direction of gaze)? Does he or she, for example, tend to adopt a hunched, inward-turned posture and avoid meeting others' eyes? Again, what does this tell you about how he or she sees him- or herself? Think too about your person's feelings and emotions. How does it feel to be him or her? Does he or she seem sad? Or fed up or frustrated? Or shy and anxious? What bodily sensations or changes might go with those emotions?

You will probably discover that clues are to be found in a number of different areas.

THOUGHTS AND STATEMENTS ABOUT THE SELF

Negative beliefs about the self find expression in what people habitually say and think about themselves. Look out for self-criticism, self-blame and self-doubt; the sense that the person does not place much value on him- or herself, discounts positives and focuses on weaknesses and flaws.

BEHAVIOR

Low self-esteem is reflected in how a person acts in everyday situations. Look out for telltale clues like difficulty in asserting needs or speaking out, an apologetic stance, avoidance of challenges and opportunities. Look out too for small clues like a bowed posture, downturned head, avoidance of eye contact, hushed voice and hesitancy.

EMOTIONS

Low self-esteem has an impact on emotional state. Look out for signs of sadness, anxiety, guilt, shame, frustration and anger.

BODY STATE

Emotional state is often reflected in uncomfortable body sensations. Look out for signs of fatigue, low energy or tension.

Your observations show how holding a central negative belief about oneself reverberates on all levels, affecting thinking, behavior, emotional state and body sensations. Consider how this may apply to you. If you were observing yourself as you have just now observed another person, what would you see? What would be the telltale clues in your case?

The impact of low self-esteem on life

Just as low self-esteem is reflected in many aspects of the person, so it has an impact

on many aspects of life.

SCHOOL AND WORK

There may be a consistent pattern of underperformance and avoidance of challenges, or perhaps rigorous perfectionism and relentless hard work, fuelled by fear of failure. People with low self-esteem find it hard to give themselves credit for their achievements, or to believe that their good results are the outcome of their own skills and strengths.

PERSONAL RELATIONSHIPS

In their relationships with others, people with low self-esteem may suffer acute (even disabling) self-consciousness, oversensitivity to criticism and disapproval, excessive eagerness to please – even outright withdrawal from any sort of intimacy or contact. Some people adopt a policy of always being the life and soul of the party, always appearing confident and in control, or always putting others first, no matter what the cost. Their belief is that, if they do not perform in this way, people will simply not want to know them.

LEISURE ACTIVITIES

How people spend their leisure time can also be affected. People with low self-esteem may avoid any activity in which there is a risk of being judged (art classes, for example, or competitive sports), or may believe that they do not deserve rewards or treats or to relax and enjoy themselves.

SELF-CARE

People with low self-esteem may not take proper care of themselves. They may struggle on when they feel ill, put off going to the hairdresser or the dentist, not bother to buy new clothes, drink excessively or smoke or use street drugs. Or, conversely, they may spend hours perfecting every detail of how they look, convinced that this is the only way to be attractive to other people.

Variations in the role and status of low self-esteem

Not everyone is affected to the same extent by central negative beliefs about the self. The impact of low self-esteem depends in part on its exact role in your life.

Low self-esteem can be an aspect of current problems

Sometimes a negative view of the self is purely a product of current mood. People who are clinically depressed almost always see themselves in a very negative light. This is true even for depressions which respond very well to antidepressant medication, and for those which have a strong biochemical basis. These are the recognized signs of clinical depression:

- Low mood (feeling consistently sad, depressed, down or empty)
- A general reduction in your capacity to experience interest and pleasure
- Changes in appetite and weight (marked increases or decreases)
- Changes in sleep pattern (again, marked increases or decreases)
- Being either so fidgety and restless that it is difficult to sit still or slowed up compared to your normal speed of going about things (this should be visible to others, not just a feeling inside yourself)
- Feeling tired and low in energy
- Feeling extremely guilty and worthless
- Difficulty concentrating, thinking straight, making decisions
- Feeling that things are so bad that you might be better off dead, or even thinking of hurting yourself

To be recognized as part of a depression that deserves treatment in its own right, at least five of these symptoms (including low mood or loss of pleasure and interest) should have been present consistently over an extended period (two weeks or more). That is, we are not talking here about the fleeting periods of depression that everyone experiences from time to time when things are rough, but rather about a mood state that has become persistent and disruptive.

If your current poor opinion of yourself started in the context of this kind of depression, then seeking treatment for the depression in its own right should be your first priority. Successfully treating the depression could even restore your confidence in yourself without you needing to work extensively on self-esteem. That said, you may still find some of the ideas in this book useful: especially Chapters 5, 6 and 7, which discuss how to tackle self-critical thoughts, how to focus on positive aspects of yourself and give yourself credit for your achievements, and how to change unhelpful rules for living. You may also find it helpful to consult another book in this series, Paul Gilbert's *Overcoming Depression*.

Low self-esteem can be a consequence of other problems

Loss of self-esteem is sometimes a consequence of some other problem which causes distress and disruption in a person's life. Long-standing anxiety problems, for example, including apparently uncontrollable panic attacks, can impose real restrictions on what a person can do, and so undermine confidence and lead to feelings of incompetence and inadequacy. Enduring relationship difficulties, hardship, lasting severe stress, chronic pain and illness can have a similar impact. All of these difficulties may result in demoralization and loss of self-esteem. In this case, tackling the root problem may provide the most effective solution to the problem. People who learn to manage panic and anxiety, for example, are often restored to previous levels of confidence without needing to do extensive work on low self-esteem in its own right. If this is your situation, and your low self-esteem developed as a consequence of some other problem, you may nonetheless find some useful ideas in this book to help you to restore your belief in yourself as swiftly and completely as possible. It could also be worth your while to consult other titles in this series to see whether any of them address your problems directly.

Low self-esteem can be a vulnerability factor for other problems

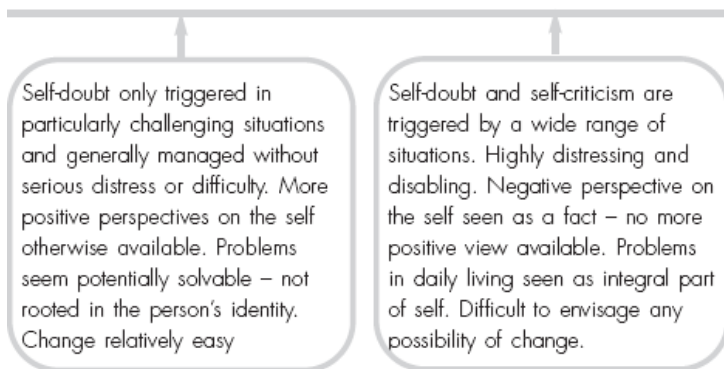
Sometimes low self-esteem, rather than being an aspect or consequence of current

problems, seems rather to be the fertile soil in which they have grown. It may have been in place since childhood or adolescence, or as far back as the person can remember. Research has shown that low self-esteem (lasting negative beliefs about the self) may contribute towards a range of difficulties, including depression, suicidal thinking, eating disorders and social anxiety (extreme shyness). If this is true for you, if the difficulties you are currently having seem to you to reflect or spring from an underlying sense of low self-esteem, then working with current problems will undoubtedly be useful in itself, but will probably not produce significant or lasting changes in your view of yourself. And unless the issue of low self-esteem is tackled directly, in its own right, you are likely to remain vulnerable to future difficulties. In this case, you could benefit greatly from using this book as a guide to working consistently and systematically on your beliefs about yourself, undermining the old negative views and building up new and more helpful perspectives.

Variations in the impact of low self-esteem

Whether low self-esteem is an aspect or consequence of other difficulties, or a vulnerability factor for them, the extent to which it impinges on life will vary from person to person. This point is illustrated on the following scale:

Low self-esteem: Variations in impact



A person with low self-esteem might fall anywhere on this scale. At the left-hand end would be found people who experience occasional moments of self-doubt, usually under very specific conditions (for example, a job interview, or asking someone out for a first date). Such doubts interfere only minimally with people's lives. They might feel mildly apprehensive in a challenging situation, but would have no real trouble managing the apprehension, would give it little weight, would find it easy to reassure themselves, and would not be held back from meeting the challenge successfully. When people like this have difficulties in life, they tend to see them straightforwardly as problems to be solved, rather than as a sign that there is something fundamentally wrong with them as a person. In addition to the negative perspective on the self triggered by challenges, they probably have other more positive and constructive alternative views, which influence how they feel about themselves most of the time.

They may well find it easy overall to relate to other people, and feel comfortable about asking for help. Such people should find it relatively easy to isolate the situations in which they experienced self-doubt, consolidating and strengthening positive perspectives on the self which are already in place and learning quite rapidly to challenge anxious predictions about performance and to answer self-critical thoughts.

At the other end of the scale would fall people whose self-doubt and self-condemnation were more or less constant. For them, no more positive alternative perspective on the self is available. This is simply the way things are. The slightest thing is enough to spark off a torrent of self-critical thoughts. They find it hard to believe in their capacity to deal with any of life's challenges, or to achieve lasting closeness to other people. Their fears and their negative beliefs about themselves may be powerful enough to cause widespread disruption in how they go about their lives – opportunities missed, challenges avoided, relationships spoiled, pleasures and achievements sabotaged, and self-defeating and self-destructive patterns of behavior in many areas. When people at this end of the scale have difficulties, rather than seeing these as problems to be solved, they tend to view them as central to their true selves ('This is me', 'This is how I am'). So it is hard to step back far enough to see things clearly, or to work systematically to change things for the better without outside help. Even then, making progress can be tough, because it is difficult to have confidence in the possibility of change or to persist if improvement is slow in coming.

Most of us fall somewhere between these two extremes. This book may have limited relevance for people falling right at the left-hand end, though it could still be a useful source of handy tips for fine-tuning an already robust sense of self-confidence and self-worth. For those who fall at the far right-hand end of the scale, using the book on its own may not be enough. It could, however, be helpful as part of a program of therapy with a cognitive behavioral therapist. Its main use will be for the people who fall in the broad middle area of the continuum – people whose low self-esteem is problematic enough for them to wish to do something about it, but who have enough freedom of movement to be able to stand back from how they habitually see themselves and search for alternative perspectives.

How to use this book

You may be a person who is generally self-confident but suffers from occasional moments of self-doubt in particularly challenging situations. Or you may be someone who is plagued by self-criticism and finds it hard to think of anything good about yourself. The chances are, you are somewhere in between. Whatever the intensity and breadth of impact of your particular brand of low self-esteem, this book provides your road map for a journey towards self-knowledge and self-acceptance. It is intended to help you to understand the origins of your poor opinion of yourself, and to discover how unhelpful thinking habits and self-defeating patterns of behavior keep it going in the present day. You will learn how to use close self-observation as a basis for introducing changes designed to help you to challenge your negative sense of yourself and to develop a new, more kindly, respectful and accepting view.

You do not have to believe that this book will revolutionize your life and make a new person of you. The key things are:

- Keeping an open mind
- Being willing to experiment with new ideas and skills
- Being willing to invest time and effort in regular self-observation and practice.

Throughout the book, you will find plenty of opportunities to think about how you developed your poor opinion of yourself, and to reflect on how low self-esteem is affecting you on a daily basis. There are lots of practical exercises and record sheets, to help you apply what you read to your own personal situation. Exactly how you use the book will be up to you. You may decide to skip quickly through it, picking up one or two handy tips. Or you may decide, after you have skimmed the chapter headings, that it would be worth investing time and effort in working through the book systematically, carefully observing how you react in situations that trouble you so that you can change old patterns, rethink your normal strategies for getting by, undermine old, negative beliefs about yourself, and replace them with more helpful and realistic alternatives.

If so, you may find it most helpful to proceed one chapter at a time, since each introduces ideas and skills that will be useful to you as you proceed, and each is built on the foundations of the last. In this case, first read the chapter through quite quickly, to give yourself a general sense of what it is about. You can use this overview to notice stories and examples that ring bells for you, and to begin to consider how the chapter is relevant to you personally – after all, you are the expert on yourself. Then go back and read the chapter more carefully, in detail, completing the exercises as you go. Do not move on to the next chapter until you feel you have got a good grasp of the change methods introduced – a sense that you understand what they are and how to use them, and that you are beginning to get results. If you rush on, you risk completing nothing properly. In this case, the ideas presented will not be able to have any significant impact on how you feel about yourself. It takes the time it takes – and you are worth it.

If you do decide to work through the book systematically, it will take time. You will probably get most out of it if you set aside a certain amount of time every day (say, 20–30 minutes) to read, reflect, plan what to do and review your records. This is undoubtedly a real commitment, particularly as the book will sometimes ask you to think about events and issues that may be painful to you. However, especially if your doubts about yourself are long-standing and if they distress you and restrict your life, then the commitment could have a substantial payoff. There may be times when you get stuck and can't think how to take things forward, or can't find alternatives to your usual way of thinking. Don't get angry with yourself or give up – put your work to one side for a time and come back to it later, when your mind has cleared and you are feeling more relaxed. You may also find it helpful to work through the book with a friend. Two heads are often better than one, and your stuck points may not be the same as his or hers. You may be able to help each other out, encouraging each other to persist, making sure you make the most of experiments in new ways of operating, sharpening your focus on positive aspects of the self, and thinking creatively about how to treat yourself like someone you value, love and respect.

A note of caution

This book will not help everyone who has low self-esteem. Sometimes a book is not

enough. The most common way of dealing with things that distress us is to talk to someone else about them. Often, talking to a loved family member or a good friend is enough to relieve distress and move us forward. Sometimes, however, even this is not enough. We need to see someone professionally trained to help people in distress – a doctor, a counsellor or a psychotherapist. If you find that focusing on self-esteem is actually making you feel worse instead of helping you to see clearly and think constructively about how to change things for the better, or if your negative beliefs about yourself and about the impossibility of change are so strong that you cannot even begin to use the ideas and practical skills described, then it may be that you would do well to seek professional help. This is especially true if you find yourself becoming depressed in the way that was described earlier, or too anxious to function properly, or if you find yourself starting to contemplate self-defeating and self-destructive acts.

There is nothing shameful about seeking psychological help – any more than there is anything shameful about taking your car to a garage if it is not running properly, or going to see a lawyer if you have legal problems you cannot resolve. Seeking help means opening a door to the possibility of a different future. It means taking your journey towards self-knowledge and self-acceptance with the help of a concerned and friendly guide, rather than striking out alone. If you feel comfortable with the approach described in the book, its practical focus and emphasis on personal empowerment through self-observation and systematic change, then your most helpful guide might be a cognitive behavior therapist.

The approach: Cognitive behavior therapy

‘Cognitive behavior therapy’ is a form of psychotherapy that was originally developed in the United States by Professor Aaron T. Beck, a psychiatrist working in Philadelphia. It is an evidence-based approach with a solid foundation in psychological theory and clinical research. It was first shown to be effective as a treatment for depression in the late 1970s. Since then, it has broadened in scope, and is now used successfully to help people with a much wider range of problems, including anxiety, panic, relationship difficulties, sexual difficulties, eating problems (like anorexia and bulimia nervosa), alcohol and drug dependency, and post-traumatic stress. You will find other books in this series dealing with some of these problems.

Cognitive behavior therapy is an ideal approach for low self-esteem. This is because it provides an easily grasped framework for understanding how the problem developed and what keeps it going. In particular, cognitive behavior therapy focuses on thoughts, beliefs, attitudes and opinions (this is what ‘cognitive’ means) and, as we have already noted, a person’s opinion of him- or herself lies right at the heart of low self-esteem.

Do not assume, however, that understanding and insight alone are enough. Cognitive behavior therapy offers practical, tried-and-tested and effective methods for producing lasting change. It does not stop at the abstract, verbal level – it is not just a ‘talking therapy’. It encourages you to take an active role in overcoming low self-esteem, to find ways of putting new ideas into practice on a day-to-day basis, acting differently and observing the impact of doing so on how you feel about yourself (this is the ‘behavioral’ element).

This is a commonsensical, down-to-earth approach to fundamental issues. It will encourage you to attend to and alter broad ideas you have about yourself, other people and life. It will also encourage you to adopt an experimental approach to how you behave in everyday situations, trying out new ideas in practice at work, with your friends and family, and in how you treat yourself, even when you are at home all on your own. The cognitive behavioral approach empowers you to become your own therapist, developing insight, planning and executing change, and assessing the results for yourself. The new skills you develop and practise will continue to be useful to you for the rest of your life.

The end result could be changes in all the areas we identified at the beginning of the chapter:

- A more balanced *perception of yourself*, which pays attention to all sides of you, rather than simply focusing on the negative and screening out the positive.
- A more balanced *self-image* or *self-concept*, which appreciates and celebrates you in the round, fully, warts and all, as you really are – in a word, *self-acceptance*.
- Increased *self-confidence* and *self-efficacy* – you have a less restricted view of your abilities, your qualities, assets, skills and strengths, and consequently your *self-respect* has grown.
- A new, enhanced sense of *self-worth* and *self-esteem*, a knowledge of your value, your entitlement to a place in the sun.

The shape of the book

Chapter 2 explores in greater detail where low self-esteem comes from. It will allow you to consider what experiences in your life have contributed to the way you see yourself, to see how the view you have of yourself makes perfect sense, given what has happened to you.

Chapter 3 homes in on what keeps old negative perspectives going in the present day, and how out-of-date thinking habits and unhelpful patterns of behavior work together in a vicious circle to block the development of self-esteem.

Chapter 4 suggests a first way of breaking out of the circle, showing you how to become aware of and to question negative predictions which make you anxious, restrict what you can do, and so contribute to low self-esteem.

Chapters 5 and 6 complement one another. Chapter 5 will teach you how to catch and answer self-critical thoughts, thus undermining your negative perspective on yourself. Chapter 6 offers ways of actively creating and strengthening a more positive view.

Chapter 7 moves on to consider how to change your rules for living, the strategies you have adopted to compensate for low self-esteem.

Chapter 8 discusses ways of working directly on the central view of yourself which lies at the heart of low self-esteem.

Finally, Chapter 9 suggests ways of summarizing and consolidating what you have learned, and how you might go about taking things further if you wish to do so.

You will notice that direct methods for changing your beliefs about yourself come last. This may seem odd. Surely shifting your negative beliefs about yourself should be the first thing you do? The fact is that it is usually easiest to change long-standing beliefs if you start by considering how they operate in the present day. It is interesting and useful to understand how they developed, but what most needs to

change is what keeps them in place. Changing a fundamental view of yourself (or indeed of anything else) may take weeks or months. So, by starting work at this broad, abstract level, you would be attempting the most difficult thing first. This could slow you down and might even be rather discouraging.

In contrast, changing how you think and act from moment to moment can have an immediate impact on how you feel about yourself. It may be possible to make radical changes within days. Working on your thoughts and feelings in everyday situations will help you to clarify the nature of your beliefs about yourself, and the impact they are having on your life. It will form a firm foundation for dealing with the bigger issues at a later stage. It may well also have an impact on your central negative beliefs about yourself, even before you begin to work on them directly. This is particularly likely to be the case if, as you go along, you keep asking yourself questions like:

- What are the implications of this for my beliefs about myself?
- How does this fit (or not fit) with my poor opinion of myself?
- What changes might follow from this in how I see myself as a person?

You may well find that small changes you make in your thinking and behavior will gradually chip away at the boulder of your central negative beliefs about yourself. You may even find that, by the time you reach Chapter 8, that boulder will be too small to need anything more than a few final blows. Even if you have not reduced it to this extent, the work that you have done in undermining negative thinking and focusing on the positive will stand you in good stead when you come to tackle the big, abstract issues. Chapter 8 quite explicitly draws on the work that has been done earlier in the book. This means that you will get most benefit from it when you have absorbed the ideas and skills covered in earlier chapters.

Good luck. Enjoy your journey!

CHAPTER SUMMARY

- 1 Self-esteem reflects the opinion we have of ourselves, the judgments we make of ourselves and the value we place on ourselves as people.
- 2 'Low self-esteem' means having a poor opinion of ourselves, judging ourselves unfavourably and assigning ourselves little worth or value.
- 3 At the heart of low self-esteem lie negative beliefs about the self. These are reflected in many aspects of how we operate on a day-to-day basis, and can have a considerable impact in many areas of life.
- 4 The role of low self-esteem varies. It can be an aspect or a consequence of current problems, or a vulnerability factor for a whole range of other difficulties. Whichever role it occupies, the extent to which it disrupts daily life varies from person to person.
- 5 This book provides a cognitive behavioral framework for understanding how your own low self-esteem developed and what keeps it going. It also offers practical ways of undermining old, negative beliefs about the self and establishing and strengthening new, more realistic and helpful alternative perspectives.

PART TWO

Understanding Low Self-Esteem

2

How low self-esteem develops

Introduction

At the heart of low self-esteem lie negative beliefs about the self. These may seem like statements of fact, in the same way that your height and weight and where you live are facts. Unless you are lying (you would like to be thought taller or thinner than you really are; you would prefer people to think you live in a more desirable part of the city), or not in possession of the information you would need to give an accurate account (you have not measured or weighed yourself recently; you have only just moved to a new home and have trouble recalling the address), then statements of fact like these are indisputable – and, indeed, their truth can easily be checked and verified by you and other people.

The same is not true of the judgments we make of ourselves and the worth we place on ourselves as people. Your view of yourself – your self-esteem – is an opinion, not a fact. And opinions can be mistaken, biased and inaccurate – or indeed, just plain wrong. Your ideas about yourself have developed as a consequence of your experiences in life. If your experiences have largely been positive and affirming, then your view of yourself is likely also to be positive and affirming. If, on the other hand, your experiences in life have largely been negative and undermining, then your view of yourself is likely to be negative and undermining.

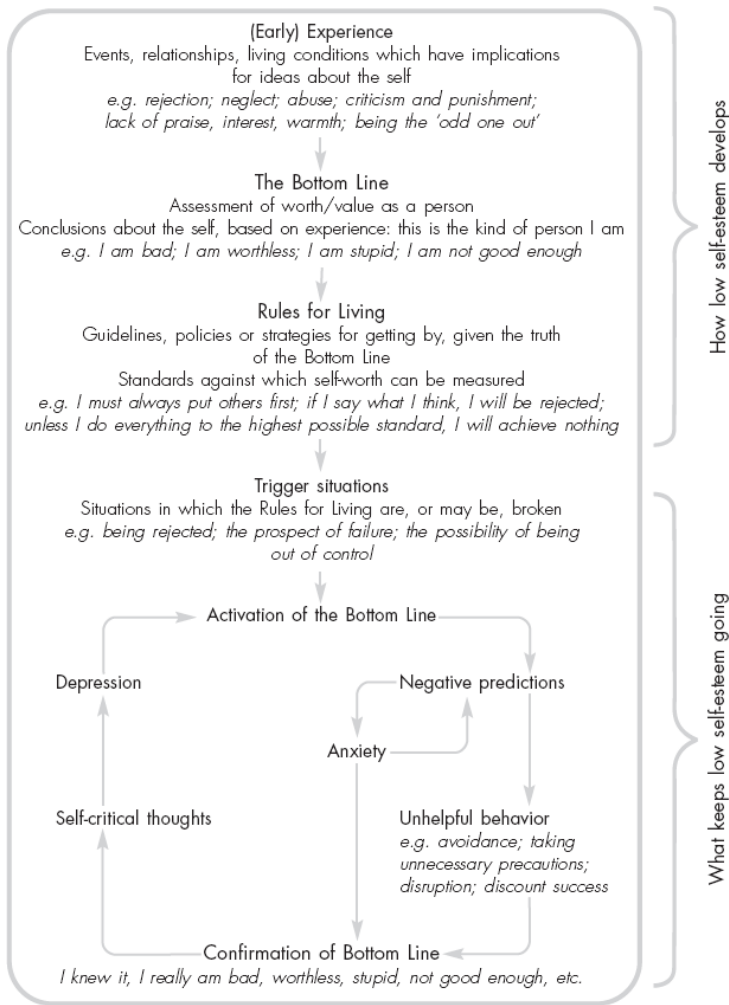
This chapter will explore how experience leads to low self-esteem and reinforces it. The processes involved in the development of low self-esteem are summarized in the top half of the flow chart on page 33. The flow chart shows how low self-esteem can be understood from a cognitive behavioral perspective. Keep it in mind as you read through the chapter. And, as you read, think about how the ideas outlined here might apply to you personally. What fits? What does not fit? What helps you to make sense of how you feel about yourself? Which of the stories told in the chapter ring bells for you? What are the experiences that have contributed to low self-esteem in your own case? What is your Bottom Line? What are your rules for living?

Keep a sheet of paper or a notebook by you, and note down anything that occurs to you as you read – ideas, memories, hunches. The aim is to help you to understand how it is that you have the view of yourself that you do, and to identify and map the experiences that have contributed to your low self-esteem. You will discover that the idea you have of yourself is an understandable reaction to what has happened to you – probably anyone who had your life experience would hold a similar view.

This understanding is the first step to change. You will begin to see how conclusions you reached about yourself (perhaps many years ago) have influenced how you have thought and felt and acted over time. The next chapter will help you to

understand how the way you operate now keeps low self-esteem going – how well-established reaction patterns prevent you from changing your opinion of yourself. That is the main implication of this new understanding: opinions can be changed. The remaining chapters provide more detailed ideas about how to bring about change, how to undermine the old negative view of yourself and establish and strengthen a more positive, kindly, accepting alternative.

Figure 1 Low self-esteem: A map of the territory



How experience leads to low self-esteem

Cognitive therapy is based on the idea that beliefs about ourselves (and indeed about other people and about life) are all learned. They have their roots in experience. Your

beliefs about yourself can be seen as conclusions you have come to on the basis of what has happened to you. This means that, however unhelpful or outdated they may now be, they are nonetheless understandable – there was a time when they made perfect sense, given what was going on for you.

Learning comes from many sources – direct experience, observation, the media, listening to what people around you say and watching what they do. Crucial experiences in terms of beliefs about the self often (though not necessarily) occur early in life. What you saw and heard and experienced in childhood in your family of origin, in the society in which you lived, at school and among your peers will have influenced your thinking in ways which may have persisted to the present day. A range of different experiences may have contributed to thinking badly of yourself. Some of these are summarized below. Each is then considered in more detail.

Figure 2 Experiences contributing to low self-esteem

<p>Early experiences:</p> <ul style="list-style-type: none">• Systematic punishment, neglect or abuse• Failing to meet parental standards• Failing to meet peer group standards• Being on the receiving end of other people's stress or distress• Belonging to a family or social group which is a focus for prejudice• An absence of good things (e.g. praise, affection, warmth, interest)• Being the 'odd one out' at home• Being the 'odd one out' at school <p>Later experiences:</p> <ul style="list-style-type: none">• Workplace intimidation or bullying, abusive relationships, persisting stress or hardship, exposure to traumatic events
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Systematic punishment, neglect or abuse

Your idea of yourself and sense of your own worth may be a result of how you were treated early in life. If children are treated badly, they often assume that this reflects something bad in themselves – they must somehow have deserved it. If you were frequently punished (especially if the punishment was excessive, unpredictable or made no sense to you), if you were neglected, abandoned or abused, these experiences will have left a psychological scars. They will have influenced how you see yourself.

Briony, for example, was adopted by her father's brother and his wife after both her parents were killed in a car crash when she was seven. Her new step-parents already had two older daughters. Briony became the family scapegoat. Everything that went wrong was blamed on her. She could do nothing right. Briony was a loving little girl, who liked to please people. She tried desperately to be good, but nothing worked. Every day she faced new punishments. She was deprived of contact with friends, made to give up music – which she loved – and was forced to do more than her fair share of work around the house. Briony became more and more confused. She could not understand why everything she did was wrong.

One night, when she was eleven, Briony's stepfather came silently into her room in the middle of the night. He put his hand over her mouth and raped her. He told her that she was dirty and disgusting, that she had asked for it, and that if she told anyone what had happened, no one would believe her, because they all knew she was a filthy little liar. Afterwards, she crept around the house in terror. No one seemed to notice

or care. Briony's opinion of herself crystallized at that point. She was bad. Other people could see it, and would treat her accordingly.

Failing to meet parental standards

Briony's experiences were extreme. It is not necessary to be systematically abused in this way to develop a poor opinion of yourself. Much less extreme punishment and criticism will also leave a mark. If others treated you as if nothing you did was good enough, focused on your mistakes and weaknesses at the expense of your successes and strengths, teased or ridiculed you, put you down or made you feel small, all these experiences (even if much less intense) may have left you with the sense that there was something fundamentally wrong with you, or that you were lacking in some way.

Jesse's father was an insurance salesman. He had never realized his ambitions to rise to a manager's position, and put this down to the fact that his parents had failed to support him during his years at school. They had never seemed particularly interested in what he was doing, and it was easy to skip school and neglect his homework. He was determined not to make the same mistake with his own children. Every day, at the supper table, he would interrogate them about what they had learned. Everyone had to have an answer, and the answer had to be good enough.

Jesse remembered dreading the sight of his father's car in the drive when he came home. It meant another grilling. He was sure his mind would go blank and he would be unable to think of anything to say. When this happened, his father's face would fall in disappointment. Jesse could see that he was letting his father down. He felt he fully deserved the close questioning that followed. 'If you can't do better than this,' his father would say, 'you'll never get anywhere in life.' In his heart of hearts, Jesse agreed. It was clear to him that he was not good enough: he would never make it.

Failing to meet peer group standards

Children and young people can be powerfully influenced, not only by their parents' explicit or implied standards, but also by the demands of others of the same age. Particularly during adolescence, when the sense of oneself as an independent person is coming into being, and when sexual identity is developing, the pressure to conform can be very strong. Seeing yourself as failing to make the grade in relation to standards in your peer group can be a painful experience, with lasting implications for self-esteem.

Karen, for example, was an attractive, sturdy, energetic girl who enjoyed sport and loved dancing. She grew up at a time when the ideal body shape for women was to be tall and extremely slender. Although she was not at all overweight, Karen's natural body shape was not even close to this ideal. Her mother tried to boost her confidence by telling her that she was 'well built'. This clumsy attempt to help her to feel OK about herself backfired. 'Well built' was not what she was supposed to be. Karen's friends were all passionate about fashion and spent hours shopping and trying on clothes. Karen would join them but, in the shared changing rooms common at the time, felt excruciatingly awkward and self-conscious. Every mirror showed how far her body failed to meet the ideal. Her broad shoulders and rounded hips were just completely wrong.

Karen decided to diet. In the first couple of weeks, she lost several pounds. Her friends thought she looked great. Karen was delighted. She continued to restrict her eating and to lose weight. But somehow, no matter how she tried, she could never be thin enough. And she was constantly hungry. In the end, she gave in and began to eat normally again, and indeed to overeat. This was the beginning of a lifelong pattern of alternating dieting and overeating. Karen was never happy with her physical self. As far as she was concerned, she was fat and ugly.

Being on the receiving end of other people's stress or distress

Even in fundamentally loving families, with parents who at heart truly appreciate and value their children, changes in circumstances can sometimes create pressure and distress which have a lasting impact on children. Parents who are stressed, unhappy or preoccupied may have little patience for normal naughtiness, or the natural lack of self-control and skill that are a part of early childhood.

Geoff, for example, was an energetic, adventurous, curious little boy. As soon as he could walk, he had his fingers into everything. Whenever something caught his eye, he would run off to investigate it. He had very little fear and, even as a toddler, was climbing trees and plunging into deep water without a second thought. His mother used to say she needed eyes in the back of her head to keep track of him. Geoff's parents were proud of his adventurousness and enquiring mind, and found him funny and endearing.

When he was three, however, twin babies arrived. At the same time, Geoff's father lost his job and had to take work at a much lower rate of pay. The family moved from their house with its little garden to a small apartment on the fourth floor of a large block. With two new babies, things were chaotic. Geoff's father felt his job loss keenly, and became morose and irritable. His mother was constantly tired. In the confined space of the apartment, there was nowhere for Geoff's energy to go, and his interest and curiosity only created mess.

He became a target for anger and frustration. Because he was only little, he did not understand why this change had happened. He tried hard to sit quietly and keep out of trouble, but again and again ended up being shouted at and sometimes smacked. It was no longer possible to be himself without being told he was a naughty, disobedient boy and uncontrollable. Even into adulthood, whenever he encountered disapproval or criticism, he still felt the old sense of wrongness and despair – in a word, unacceptability.

Your family's place in society

It may be that your beliefs about yourself are not simply based on how you personally were treated. Sometimes low self-esteem is more a product of the way a person and his or her family lived, or his or her identity as a member of a group. If, for example, your family was very poor, if your parents had serious difficulties which meant the neighbours looked down on them, if you were a member of a racial, cultural or religious group which was a focus for hostility and contempt, you may have been contaminated by these experiences with a lasting sense of inferiority to other people.

This was true for **Arran**, whose story shows how a feisty, attractive child can

come to believe he has nothing to contribute because his family group is rejected by the society in which he lives.

Arran was the middle one of seven children, in a family of travellers. He was brought up by his mother and his maternal grandmother and had no consistent father figure. Life was tough. There were constant financial strains, and was little permanence of any kind. Arran's grandmother, a striking woman with brightly bleached hair, coped by drinking. Arran had clear memories of being rushed through the streets to school, his grandmother pushing two babies crammed into a buggy, the older children and another whining toddler trailing behind. Lack of money meant that all the children wore second-hand clothes, which were passed down from one to the next. Their sweatshirts were grubby, their shoes scuffed, their faces smudged, their hair standing on end. Every so often, the grandmother would stop and screech at the older children to hurry up.

What stuck in Arran's mind was the faces of people coming in the opposite direction as they saw the family approaching. He would see their mouths twist, their frowns of disapproval, their avoidance of eye-contact. He could hear their muttered comments to one another. The same happened when they reached the school. In the playground, other children and parents gave the family a wide berth.

Arran's grandmother, too, was well aware of other people's stance. She was fiercely protective of the family, in her own way. She would begin shouting and swearing, calling names and screaming threats.

Throughout his schooldays, Arran felt a deep sense of shame. He saw himself as a worthless outcast, whose only defence was attack. He was constantly fighting and scuffling, failed to engage in lessons, left with no qualifications, and became involved with other young men operating on the fringes of the law. The only time he felt good about himself was when he had successfully broken the rules – stolen without being caught or beaten someone up without reprisals.

An absence of good things

It is easy to see how painful experiences like those described above could contribute towards feeling bad, inadequate, inferior, weak or unlovable. Sometimes, however, the important experiences are less obvious. This may make how you feel about yourself a puzzle to you. Nothing so extreme happened in your childhood – how come you have so much trouble believing in your own worth?

It could be that the problem was not so much the *presence* of dramatically bad things, but rather an *absence* of the day-to-day good things that contribute to a sense of acceptability, goodness and worth. Perhaps, for example, you did not receive *enough* interest, *enough* praise and encouragement, *enough* warmth and affection, *enough* open confirmation that you were loved, wanted and valued. Perhaps in your family, although there was no actual unkindness, love and appreciation were not directly expressed. If so, this could have influenced your ideas about yourself.

Kate, for example, was brought up by elderly parents from a strict middle-class background. At heart, both were good people who tried their best to give their only daughter a good upbringing and a sound start in life. However, the values they had grown up with meant that both of them had difficulty in openly expressing affection. Their only means of showing how much they loved her was through caring for her practical needs. So, they were good at ensuring that Kate did her homework, in

seeing that she ate a balanced diet, that she was well dressed and had a good range of books and toys.

As she grew older, they made sure she went to a good school, took her to girl guides and swimming lessons, and paid for her to go on holiday with friends. But they almost never touched her – there were no cuddles, no kisses or caresses, no pet names. At first, Kate was hardly aware of this. But once she began to see how openly loving other families were, she began to experience a sad emptiness at home. She did her best to change things. She would take her father's hand as they walked along – and noticed how he would drop it as soon as he decently could. She would put her arms round her mother – and feel how she stiffened. She tried to talk about how she felt – and saw how awkward her parents looked, and how they swiftly changed the subject.

Kate concluded that their behavior towards her must reflect something about her. Her parents did their duty by her, but no more. It must mean she was fundamentally unlovable.

Being the 'odd one out' at home

Another more subtle experience that can contribute to low self-esteem is the experience of being the 'odd one out'. I mean by this someone who did not quite 'fit' in your family of origin. Perhaps you were an artistic child in an academic family, or an energetic, sporty child in a quiet family, or a child who loved reading and thinking in a family who were always on the go. There was nothing particularly wrong with you, or with them, but for some reason you did not match the family template or fit the family norm. It could be that you were never subject to anything more than good-natured teasing, or perhaps mild puzzlement. But sometimes people in this situation take away a sense that to be different from the norm means to be odd, unacceptable, or inferior.

Sarah was an exceptional artist. Both her parents, however, were teachers who thought that to achieve academically was the most important thing in life. They were plainly delighted with her two older brothers, who did very well at school, moved on to do well at university, and became a doctor and a lawyer. Sarah, however, was an average student. There was nothing particularly wrong with her schoolwork – she simply did not shine as her parents hoped she would.

Her real talent lay in her hands and eyes. She could draw and paint, and her collages were full of energy and colour. Sarah's parents tried to appreciate her artistic gifts, but they saw art and craft work as essentially trivial – a waste of time. They never openly criticized her, but she could see how their faces lit up when they heard about her brothers' achievements and could not help but contrast this with their lack of enthusiasm when she brought her artwork home. They always seemed to have more important things to do than look carefully at what she had done ('Very nice, dear').

Sarah's conclusion was that she was inferior to other, cleverer people. As an adult, she found it difficult to value or take pleasure in her gifts, tended to apologize for and downgrade her work as an artist, and fell silent in the company of anyone she saw as more intelligent or educated than herself, preoccupied with self-critical thoughts.

Being the 'odd one out' at school

In the same way that not fitting into one's family of origin can make it difficult to feel good about oneself, so being in some way different from others at school can lead people to see themselves as weird, alien or inferior. Children and young people who stand out in some way from the group can be cruelly teased and excluded. For many children, to be different is to be wrong. This can be true for differences in appearance (e.g. skin colour, wearing spectacles), differences in psychological make-up (e.g. shyness, sensitivity), differences in behavior (e.g. having a different accent, being openly affectionate to parents beyond the age where this is considered cool) and differences in ability (e.g. being overtly intelligent and good at school work, being slow to learn).

Chris's early childhood was happy. But he began to experience difficulties as soon as he went to school, because of undiagnosed dyslexia. While all the other children in the class seemed to be racing ahead with their reading and writing, he lagged behind. He just could not get the hang of it. He was assigned a teacher to give him special help, and had to keep a special home reading record which was different from everyone else's.

Other children started to laugh at him and call him 'thicko' and 'dumbo'. He compensated by becoming the class clown. He was the one who could always be relied on to get involved in silly pranks. The teachers too began to lose patience with him, and to label his difficulties laziness and attention-seeking. When his parents were summoned to the school yet again to discuss his behavior, his comment to them was: 'What can you expect? I'm just stupid.'

Late onset

Although low self-esteem is often rooted in experiences a person has had in childhood or adolescence, it is important to realize that this is not necessarily the case. Even very confident people, with strong favourable views of themselves, can have their self-esteem undermined by things that happen later in life, if these are sufficiently powerful and lasting in their effects. Examples include workplace intimidation or bullying, being trapped in an abusive marriage, being ground down by a long period of relentless stress or material hardship, and exposure to traumatic events.

Jim's story illustrates how solid self-confidence can be undermined in this way. Jim was a fireman. As part of his job, he had attended many accidents and fires, and had been in a position on more than one occasion to save life. He had a stable, happy childhood and felt loved and valued by both his parents. He saw himself as strong and competent, able to deal with anything life might throw at him. This was why he was able to succeed and remain outgoing and cheerful despite his tough, risky and demanding job.

One day, as he was driving down a busy street, a woman stepped off the pavement immediately in front of him, and was caught under the wheels of his car. By the time he was able to stop, she had been fatally injured. Jim always carried a first aid kit, and he got out of the car to see what he could do. After a while, however, during which other people had called an ambulance and gathered round to help, he felt increasingly sick and shocked and retreated to his car.

Like many people who have suffered or witnessed horrific accidents, Jim later

began to suffer symptoms of post-traumatic stress. He kept replaying the accident in his mind. He found the victim was ‘haunting’ him – he didn’t seem to be able to be able to get her out of his mind, asleep or awake. He was tormented by guilt – he should have been able to stop the car, he should have stayed with the victim to the bitter end. He was constantly tense, irritable and miserable – not at all his usual self.

Jim’s usual way of coping with difficulties was to tell himself that life goes on, that he must put it behind him and live in the present. So he tried not to think about what had happened, and to suppress his feelings. Unfortunately, this made it impossible for him to come to terms with what had happened. He began to feel that his personality had fundamentally changed, and for the worse. The fact that he had not been able to prevent the accident, that he had withdrawn to the car, and that he could not control his feelings and thoughts meant that, far from being the strong, competent person he had believed himself to be, he was actually weak and inadequate – a neurotic wreck.

Bridging the past and the present: The Bottom Line

These stories all show how experience shapes self-esteem. As people grow up, they take the voices of people who were important to them with them. These need not be parents’ voices. Other family members (grandparents, for example, or older siblings), teachers, child minders, friends and schoolmates – all can have a major impact on self-confidence and self-esteem. We may criticize ourselves in their exact, sharp tones, call ourselves the same unkind names, and make the same comparisons with other people and with how we ought to be. That is, the beliefs we hold about ourselves in the present day often directly reflect the messages we received as children.

Along with this, we may re-experience emotions and body sensations, and see images in our mind’s eye that were originally present at a much earlier stage. Sarah, for example, when she submitted a painting for exhibition, would hear her mother’s patient voice (‘Well, I suppose if *you* like it, dear’) and experience the same sinking feeling in her stomach that she experienced as a child. Geoff, when in the best of spirits and full of energy and ideas, would suddenly catch a flash in his mind’s eye of his father’s distorted, shouting, angry face and feel instantly in the wrong, inappropriate and deflated.

Why is this? Life goes on, after all. We are no longer children. We have adult experience under our belt. So how come these events, so long ago, still influence how we operate in the present day?

The answer lies in the way that our experiences have created a foundation for general conclusions about ourselves, judgments about ourselves as people. We can call these conclusions the ‘Bottom Line’. The Bottom Line is the view of the self that lies at the heart of low self-esteem. The Bottom Line can often be summed up in a single sentence, beginning with the words, ‘I am . . .’ Look back over the stories you have read on the last few pages. Can you spot the Bottom Lines of the people described there?

Figure 3 The Bottom Line

† actually
† asseegood enough

† ~~attractive~~ and ugly
 † ~~admirable~~ acceptable
 † ~~admirable~~ worthless
 † ~~admirable~~ lovable
 † ~~admirable~~ important; I am inferior
 † ~~admirable~~ stupid
 † ~~admirable~~ strong and competent → I am a neurotic wreck

The distressing ideas that these people have developed about themselves flow naturally from the experiences they have been exposed to. Their opinions of themselves make perfect sense, given what has happened to them. But, when you read their stories, did you agree with those opinions? Did *you* think that Briony was bad, that Jesse was a failure, Karen fat and ugly, Geoff all wrong? In *your* opinion, did Arran deserve to be an outcast? Did *you* agree that Kate was unlovable, Sarah unimportant and inferior, Chris stupid, and Jim inadequate and weak?

As an outsider, you could no doubt see that Briony was not responsible for what was done to her, that Jesse's father's own needs were clouding his judgment, that Karen's only shortcoming was not meeting a false ideal, that Geoff's parents changed towards him because their difficult circumstances made them lose sight of his lovable qualities and made his strengths into sources of stress. It was probably clear to you that the disapproval Arran attracted was no fault of his own, that the limitations of Kate's parents restricted how loving they could be with her, that Sarah's parents' narrow standards prevented them from enjoying her gifts, that Chris's slowness to learn was nothing to do with stupidity, and that Jim's distress was a normal and understandable reaction to a horrific event, and not a sign of weakness or inadequacy.

Now think about your own view of yourself and the experiences that have fed into it, while you were growing up and perhaps also later in your life. What do you think your Bottom Line is? What do you say about yourself when you are being self-critical? What names do you call yourself when you are angry and frustrated? What were the words people in your life used to describe you when they were angry, or disappointed in you? What messages about yourself did you pick up from your parents, other members of your family or your peers? If you could capture the essence of your doubts about yourself in a single sentence ('I am _____'), what would it be?

Remember, your Bottom Line will not have come from nowhere. You were not born thinking badly of yourself. This opinion is based on experience. What experiences exactly? What comes to mind when you ask yourself when you first felt as you now do about yourself? Was there a single event which crystallized your ideas for you? Do you have any specific memories? Or was there a sequence of events over time? Or perhaps a general climate, for example of coldness or disapproval? Make a note of your ideas. You will be able to use this information later on as a basis for changing your perspective on yourself.

Understanding the origins of low self-esteem is the first step towards change. You can probably see that the conclusions Briony and the others reached about themselves were based on misunderstandings about the meanings of their experiences – misunderstandings that make perfect sense, given that at the time they reached the conclusions they had no adult knowledge on which to base a broader, more realistic view or were too distressed to think straight.

This is the key thing about the Bottom Line at the heart of low self-esteem. However powerful and convincing it may seem, however well rooted in experience, it is usually biased and inaccurate, because it is based on a child's eye view. If your

confidence in yourself has always been low, it is likely that when your Bottom Line was formed, you were too young to say ‘hang on a minute’, stand back, take a good look at it, and question its validity; in short, to realize that it is an opinion, not a fact.

Think about your own Bottom Line. Is it possible that you have reached conclusions about yourself on the basis of similar misunderstandings? Blamed yourself for something that was not your fault? Taken responsibility for another person’s behavior? Seen specific problems as a sign that your worth as a person is low? Absorbed others’ standards before you were experienced enough to know their limitations? In particular, if you imagine another person who had had your experiences, would you judge them as negatively as you do yourself, or would you come to different conclusions? How would you understand and explain what has happened to you, if it had happened to someone you respected and cared about?

You may find it hard at this stage to approach any sort of different view. Once the Bottom Line is in place, it becomes increasingly difficult to detach oneself from it and question it. This is because it is maintained and, indeed, strengthened by systematic biases in thinking, which make it easy for you to notice and give weight to anything that is consistent with it, while encouraging you to screen out and discount anything that is not. It also leads to the development of Rules for Living: strategies for managing yourself, other people and the world, based on the assumption that the Bottom Line is true.

Biases in thinking

Two biases in thinking contribute to low self-esteem by keeping negative beliefs about the self going. These are: 1) a bias in how you perceive yourself (biased perception); and 2) a bias in what you make of what you see (biased interpretation).

1 Biased perception

When your self-esteem is low, you are primed to notice anything that is consistent with the negative ideas you have about yourself. You are swift to spot anything about yourself that you are unhappy about, or do not like. This may mean aspects of your physical appearance (e.g. your eyes are too small), your character (e.g. you are not outgoing enough) or simply mistakes that you make (‘Not again. How *could* I be so stupid?’) or ways in which you fall short of some standard or ideal (e.g. not performing 110 per cent on an assignment). All your shortcomings, flaws and weaknesses jump out and hit you in the face.

Conversely, you are primed to screen out anything that is *not* consistent with your prevailing view of yourself. It is difficult for you to get a clear view of your strengths, qualities, assets and skills. The end result is that your general focus as you go through your life is on what you do wrong, not on what you do right.

2 Biased interpretation

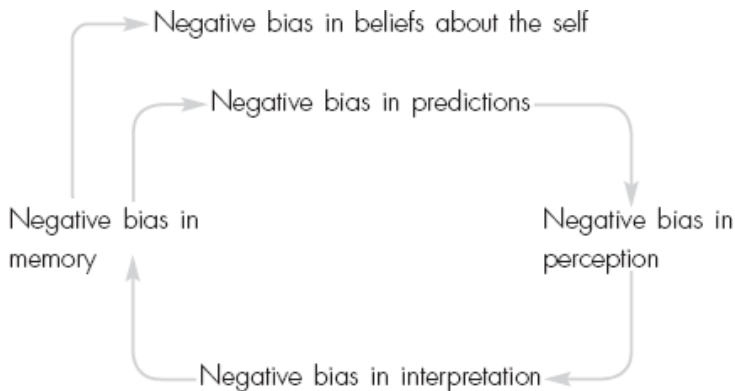
Low self-esteem not only skews your perception of yourself, but also distorts the meanings you attach to what you see. If something does not go well, you are likely to use this as the basis for a global, overgeneralized judgment of yourself – typical, you always get it wrong, etc. So even quite trivial mistakes and failings may seem to you

to reflect your worth as a person, and so have (in your eyes) major implications for the future. Neutral and even positive experiences may be distorted to fit the prevailing view of yourself. If, for example, someone compliments you on looking well, you may privately conclude that you must have been looking pretty bad up till now, or discount the compliment altogether (the exception proves the rule, they were only being kind, etc.). Your thinking is consistently biased in favour of self-criticism, rather than encouragement, appreciation, acceptance or praise.

The end result

These biases operate together to keep the system in place. Because your basic beliefs about yourself are negative, you anticipate that events will turn out in a negative way (as we shall explore in further detail in Chapter 4). The anticipation makes you sensitive to any sign that things are indeed turning out as you predicted. In addition, no matter how things turn out, you are likely to put a negative spin on events. Consequently, your stored memories of what happened will also be biased in a negative direction. This will both strengthen the negative beliefs about yourself, and make you more likely to predict the worst in future.

Figure 4 Low self-esteem: Biases in thinking



Consistent biases in thinking prevent you from realizing that your beliefs about yourself are simply opinions – based on experience, true enough, and perhaps powerfully convincing – but opinions nonetheless. And opinions increasingly based on a biased perspective, and so further and further adrift from the real you. Christine Padesky, a cognitive therapist, has suggested that it can be illuminating to consider negative beliefs about the self as akin to prejudices. ‘Prejudice’ refers to a belief which does not take account of all the facts, but rather relies on a biased sample of evidence for its support and may be powerful out of all proportion to its real truth value. It is easy to see examples of such powerful beliefs all around us – prejudices against people of certain racial or cultural or religious groups, people of particular age groups, gender or sexual orientations. Such strong opinions, with no real evidential basis, can even drive people to war.

So it is with low self-esteem. Biases in your thinking about yourself (prejudices against yourself) keep your negative views in place, make you anxious and unhappy,

restrict your life and prevent you from searching out a broader, more balanced and accurate view of the kind of person you really are.

Rules for Living

Even if you believe yourself to be in some way incompetent or inadequate, unattractive or unlovable, or simply not good enough, you still have to function in the world. Rules for Living help you to do this. They allow you to feel reasonably comfortable with yourself, so long as you obey their terms. That is, they make it possible for people to operate more or less effectively in life, despite their belief in the Bottom Line.

Paradoxically, however, they also in fact help to keep the Bottom Line in place and so maintain low self-esteem. A look at the Rules for Living of the people described above may give you a sense of how they make sense in the context of the Bottom Line, and how they work in practice to protect self-esteem.

The Rules for Living each of these people developed can be understood as an attempt to get by, an escape clause, assuming the Bottom Line to be true. On a day-to-day basis, they are expressed through specific policies or strategies. For example, Briony's rules about the dangers of exploitation and about hiding her true self led her to adopt the strategy of avoiding close relationships. She kept social contact to a minimum and, if forced to spend time with people, kept the conversation light and avoided questions about herself. She was always sharply vigilant for any signs that people might push her into doing things she did not wish to do, and fiercely protective of her personal space.

Figure 5 Rules for living

	Bottom Line	Rules for Living
Briony	I am bad	If I allow anyone close to me, they will hurt and exploit me I must never let anyone see my true self
Jesse	I am not good enough	Unless I always get it right, I will never get anywhere in life If someone criticizes me, it means I have failed
Karen	I am fat and ugly	My worth depends on how I look and what I weigh
Geoff	I am unacceptable	I must always keep myself under tight control
Arran	I am worthless	Survival depends on hitting back No matter what I do, no one will accept me
Kate	I am unlovable	Unless I do everything people expect of me, I will be rejected If I ask for what I need, I will be disappointed
Sarah	I am unimportant	If someone is not interested in me, it's because I am unworthy of interest
	I am inferior	Nothing I do is worthwhile unless it is recognized by others
Chris	I am stupid	Better not to try than to fail
Jim	I am strong and competent	I should be able to cope with anything life throws at me
	I am a neurotic wreck	Letting my emotions get the better of me is a sign of weakness

And, to some degree, such strategies work. For example, Jesse's high standards and fear of failure and criticism motivated him to perform to a consistently high level, and allowed him to make a resounding success of his working life. But he paid a price for this. His Rules for Living created an increasing sense of strain, and made it impossible for him to relax and enjoy his achievements. In addition, his need to perform meant that work dominated his life, at the expense of personal relationships and leisure time.

In Chapter 7, you will find more detail about Rules for Living, their impact on your thoughts and feelings and how you manage your life, and how to change them

and liberate yourself from the demands they place upon you.

CHAPTER SUMMARY

- 1 Your negative beliefs about yourself (your Bottom Line) are opinions, not facts.
- 2 They are conclusions about yourself based on experience (usually, but not necessarily, early experience). A broad range of experiences, including both the presence of negatives and the absence of positives, can contribute to them.
- 3 Once in place, the Bottom Line can be hard to change. This is because it is kept in place and strengthened by biases in thinking, which mean that experiences that are consistent with the Bottom Line are readily attended to and given weight, while experiences that contradict it are ignored or discounted.
- 4 The Bottom Line also leads to the development of Rules for Living, standards or guidelines which you must obey in order to feel comfortable with yourself. These are designed to help you to function in the world, given the assumed truth of the Bottom Line. In fact, they serve to keep it in place and maintain low self-esteem.

3

What keeps low self-esteem going

Introduction

Negative beliefs about yourself may have roots in the past, but their impact continues into the present day. Otherwise, you would not be reading this book! This chapter will help you to understand how everyday patterns of thinking and behavior keep low self-esteem going and prevent you from relaxing into your experiences and valuing and appreciating yourself.

We shall be looking at the vicious circle that is triggered when you find yourself in a situation in which you might break your rules for living and so activate your Bottom Line. The circle is shown in the bottom half of the flowchart on page 33, and is described in detail below. This chapter will outline how it works in practice, showing how anxious predictions and self-critical thinking affect how you feel and act in your daily life. The idea is that you should apply these ideas to yourself and explore how they fit your own thoughts, feelings and behavior. So, while you read the chapter, keep asking yourself: how does this fit? What are the situations that trigger anxious predictions in me? How do my predictions affect my emotions and my body state? What do I do (or not do) to stop them from coming true? What does confirmation of my beliefs about myself feel like for me? How do I know it is happening? What is the nature of my self-critical thoughts? What effect do they have on my feelings, on what I do – most particularly on my beliefs about myself?

You may find it helpful to keep pen and paper beside you, and draw up your own vicious circle as you go through the chapter. Use the ideas described here as an opportunity to reflect on yourself and deepen your understanding of how low self-esteem influences you on a day-to-day basis.

Triggering the system: Breaking the rules

In the last chapter, we introduced the idea that the Rules for Living that you have devised, and the day-to-day strategies through which they express themselves, can, in the short term, help to keep low self-esteem at bay. However, at the end of the day, they actually keep it going because they make demands which are impossible to meet – for example, perfection, universal love and approval, complete self-control or control over your world. This means that well-being is inevitably fragile. If you find yourself in a situation where you are in danger of breaking the rules (e.g. operating below 100 per cent, being disliked or disapproved of, losing control of yourself or your world), the Bottom Line which your rules have protected you against rears its

ugly head. Self-doubt emerges from the shadows and begins to dominate the picture. You experience a sense of uncertainty – suddenly you feel insecure.

Figure 6 Situations triggering the Bottom Line

Briony	Situations where she felt her true (bad) self might be exposed, or had been exposed
Jesse	Situations where he feared he might be unable to meet the high standards he had set himself, or where he encountered criticism
Karen	Noticing that she had gained weight, or needing to buy clothes and fearing that she might attract stares or not fit into the size she thought she should be
Geoff	Feeling high levels of energy and emotion (including positive emotions); encountering any signs of disapproval
Arran	Situations where he was vulnerable to attack or rejection, including close relationships
Kate	Being unable to do what was expected of her; having to ask for help
Sarah	Exhibiting her work to public scrutiny
Chris	Having to write, especially if he had to do it in front of other people; having to face any challenge (especially any intellectual challenge)
Jim	Noticing signs that he was still upset and not his normal self

The exact nature of the situations that activate your Bottom Line will depend on the nature of the Bottom Line itself, and on the rules you have adopted to cope with it. So, for example, if your Bottom Line concerns your acceptability to other people, and your rules are designed to ensure that acceptability, then the situations which are likely to be problematic for you are those where you fear your acceptability might be compromised. If, on the other hand, your Bottom Line concerns achievement, success or competence, and your rules focus on high standards and are designed to ensure that you always achieve these, then the situations in which you will feel threatened are those in which you might fall below what you expect of yourself. And so on.

Think back to the people you met in the last chapter. For each of them, the situations that triggered the Bottom Line were a direct reflection of the nature of their beliefs about themselves, and of their Rules for Living:

Thus the situations that activate the Bottom Line and bring it into play are those in which the rules might be broken (or have been broken), situations which raise doubts about yourself and have direct implications for how you perceive yourself and for the value you place on yourself as a person. These may be quite major events, e.g.

a broken relationship, a job lost, a serious illness or a child leaving home. However, many of the situations which rouse self-doubt and uncertainty on a day-to-day basis are on a much smaller scale. Many are small ups and downs of a kind you may not even be fully aware of, or may brush aside with 'Don't be silly', or 'Come on, pull yourself together'.

If you want fully to understand what keeps your poor opinion of yourself going, tuning into these small events is a crucial step. In the chapters to come, you will learn how to become more sensitive to the changes in mood that tell you that your Bottom Line is activated, and how to observe the thoughts, feelings and behavior that follow from activation. For now, just reflect for a moment. Think over the last week. Were there any moments when you felt anxious or ill at ease, uncomfortable with yourself, or doubtful about your ability to handle what was going on? Were there any times when you suspected that you were not coming over as you might wish to do, felt a bit useless, or attracted worrying reactions from other people? Did you at any point feel that things were getting on top of you, or as if you were not operating at the level you expect of yourself?

Make a note of those situations. Do you notice any patterns? If so, what does this tell you about your own personal Rules for Living – what you require of yourself and what you need from other people, in order to feel good about yourself? What rules were you breaking, or in danger of breaking? What kind of ideas about yourself came into your mind in those situations? Were you aware of using any uncomplimentary words to describe yourself? What were they? They may reflect your central negative beliefs about yourself (your Bottom Line).

The response to threat: Anxious predictions

Once the Bottom Line is activated, the uncertainty inherent in the situation that triggered it gives rise to specific negative predictions (fears about what might happen), whose content depends on the nature of your particular concerns.

To illustrate this, let us take a situation which most people find somewhat intimidating, but which for a person with low self-esteem can be real torture. Suppose you had to stand up and give a talk to a group of people, i.e. speak in front of an audience. Imagine having to do this in any situation with which you are familiar – work, perhaps, or your church, an evening class you have attended, the clinic you take your baby to, or your child's school assembly. What is your immediate reaction when you contemplate having to stand up and speak in public? What thoughts come to mind? 'I couldn't do it'? 'I'd make a total fool of myself'? 'No one would want to listen to me'? 'I'd get so anxious I would have to run out'?

Or do you perhaps have an image in your mind's eye of what might happen? Yourself red in the face and sweating and everyone staring, for example? Or people gazing out of the window and looking bored and irritated? Or perhaps trying to look kindly on you, but in their heart of hearts thinking what a sad case you are? The thoughts that spring to mind when you contemplate giving a talk in public are likely to be about what you think might happen, and in particular what you envisage might go wrong. That is, they are your own personal view of the future – negative predictions which, as we shall see, have a powerful impact on your feelings and on your behavior.

For a person with low self-esteem confronted with the need to speak in public,

what immediately springs to mind will be all the ways in which the presentation could go wrong. He or she will probably assume that the worst will happen, and that there is little or nothing that can be done to prevent it. Just as the situations that activate the Bottom Line vary from person to person, depending on its focus of concern, so the exact nature of the negative predictions will vary from person to person, depending on what is most important to them. When Arran imagined the public speaking scenario, for example, he predicted that people would write him off before he even opened his mouth – no one would accept that someone like him could possibly have anything to say that was worth listening to. Jane's main concern, in contrast, was that she would fail to meet her audience's expectations. Sarah's prediction was simply that people would be bored. Geoff thought he would make a fool of himself by saying something inappropriate. People would consider he was showing off. Jim was concerned that he would be nervous, and that it would show.

You can see here how each person's predictions stem from the beliefs they have about themselves, and from the rules they have devised to compensate for those beliefs. Once you know their stories, their fears make perfect sense. In Chapter 4, you will be learning how to tune into your own anxious predictions by observing your reactions in situations which make you nervous and observing your thoughts, the words or images which come into your mind when you feel your self-esteem is in danger of being compromised. This is important, because negative predictions, if unchallenged, have a powerful impact on your emotional state and on your behavior, and so contribute to keeping low self-esteem going. Let us consider this by continuing the public speaking example.

The impact of negative predictions on your emotional state

Put yourself back into the public speaking scenario. Imagine the worst that could happen. Make your anxious predictions as real as you can. What happens to your emotional state when you do this? What changes do you notice in how you feel?

Predicting that things will go wrong normally leads to anxiety. This may not be quite the word you would use – perhaps you feel apprehensive, nervous, uptight, frightened, panicky or even terrified. You will recognize all these as varieties of fear. Now, notice what happens in your body when you are afraid. What changes do you observe? What happens to your heart rate? Your breathing? The level of tension in your muscles? Which muscles in particular have tightened up? Do you notice any sweating – perhaps on your forehead, or the palms of your hands? Do you feel shaky? What about your digestive system? Do you notice any sensations in your stomach – fluttery feelings, perhaps, or a churning sensation?

All these are physical signs of anxiety, the body's wired-in response to threat.

To a person with low self-esteem, these normal reactions may seem to have a more sinister meaning. They could become a source of further anxious predictions (this mini-vicious circle is illustrated on the right-hand side of the bottom half of the flow chart on page 33). If your mouth had gone dry, for example, you might fear that you would be unable to speak. If your hands were feeling shaky, you might predict that your nervousness would be obvious to your audience, and that they would think you incompetent or weird. If, when you are anxious, your mind tends to go blank, you may worry that you will appear tongue-tied or incoherent, or as if you don't know what you are talking about. Such reactions to signs of anxiety naturally tend to

intensify it and add to the stress of the situation.

The impact of anxious predictions on your behavior

Anxious predictions can affect your behavior in a number of unhelpful ways. To understand how this works, let us go back to the public speaking scenario again.

Anxious predictions can lead to avoidance

If you believed your anxious predictions strongly enough, you might simply decide to avoid the situation altogether. You might phone the person who had organized your presentation and tell them you had flu and would not be able to make it. Or you might simply not turn up.

This would mean that you had no opportunity to discover whether or not your anxious predictions were in fact correct. It could be that things would actually have gone much better than you predicted – events are often much less intimidating in reality than they are in anticipation. Avoiding the situation stops you from finding this out for yourself. So avoidance, although it may help you feel better in the short term (what a relief – you got out of it), ultimately contributes to keeping low self-esteem going.

The implication of this, when we come to consider how to change current patterns, is that, in order to develop your confidence in yourself and your self-esteem, you will need to begin approaching situations that you have been avoiding. Otherwise, your life will continue to be restricted by your fears, and you will never gain the information you need to have a realistic, positive perspective on yourself.

Anxious predictions can lead to unnecessary precautions

Rather than avoiding the situation altogether, you might decide to go and give your talk, but put in place a whole range of precautions designed to ensure that your worst fears do not come true – that you manage to obey your rules and escape from the situation with your self-esteem intact. So, for example, Jane thought she would need to spend a great deal of time considering carefully what people might want to hear and trying to include all the possibilities in her talk. During the talk itself, she would be watching constantly for signs that people were not happy with what she was saying, and would smile a lot at her audience. Jesse, on the other hand, believed that the crucial thing was to appear 100 per cent confident and competent, and thought he would rehearse and rehearse and rehearse what he was going to say in order to get the content and presentation style absolutely right in every detail. He would make sure his talk filled all the time available, so that there would be no time for questions which he might not be able to answer.

What would you do if you had to give a public presentation, in order to ensure that your worst fears were not realized?

The problem with self-protective manoeuvres like these is that, however well things go, you are left with the feeling that you had a 'near miss'. If you had not taken these precautions, then the worst would have happened. So again, you will not have had the opportunity to find out for yourself whether your fears were actually true or not, to discover that your precautions were excessive and even unnecessary.

You will be left with the sense that your success (and so your feeling of self-worth) was entirely due to the precautions you took. In practice, this means that part of becoming more confident and content with yourself is to approach situations empty-handed where you normally use precautions. Only by doing this will you discover that your precautions are unnecessary – you can get what you want out of life without them.

Anxious predictions can disrupt performance

It is possible, on occasion, that your performance is quite genuinely disrupted by anxiety. You find yourself stammering, you can see your notes shaking in your hand or your mind genuinely does go blank. These things happen, even to accomplished speakers. Supposing something like this happened to you: what would your reaction be? What thoughts might come into your mind?

People with robust self-esteem might observe the signs of nervousness with interest or detachment rather than fear, and see them as an understandable reaction to being under pressure. They might believe that to be nervous under these circumstances is quite normal, and be pretty confident that their anxiety was much less evident to other people than it was to them, and that even if others noticed, they would not make much of it. In short, as far as confident people are concerned, being anxious does not matter particularly. Their personal rules accommodate a less than perfect performance, and they would not see it as having any real significance for their worth.

If you have low self-esteem, however, then you are likely to see any difficulties or imperfections as evidence of your usual uselessness, incompetence, or whatever. That is, they say something about you *as a person*. Naturally enough, this also feeds into keeping low self-esteem going. Life being what it is, you will not always operate as you might wish to do. A part of overcoming low self-esteem is to begin to view your weaknesses and flaws – the things you do not do particularly well and the mistakes you make – as simply a part of yourself and an aspect of being human, rather than a reason for condemning yourself as a total person.

Anxious predictions can lead to success being discounted

Despite your anxieties, your presentation might in fact go just fine. You say what you wanted to say, people seem interested, your nervousness does not get out of hand, there are some interesting questions and you find good answers to them. Supposing this happened to you: what would your reaction be? Would you feel good about yourself – you did a good job, and you deserve a pat on the back? Or would you have a sneaking suspicion that you did it by the skin of your teeth: the audience were just being kind, you were lucky, or the stars were on your side? But *next* time . . .

Even when things go well, low self-esteem can undercut your pleasure in what you achieve and make you likely to ignore, discount or disqualify anything that does not fit with your prevailing negative view of yourself. The ‘prejudice’ against yourself described in Chapter 2 prevents you from taking in and accepting evidence that contradicts it. So part of overcoming low self-esteem is to begin to notice and take pleasure in your achievements and in the good things in your life. Chapter 6 will focus in detail on how to go about this.

Confirmation of the Bottom Line

Whether you avoid challenging situations altogether, hedge them about with unnecessary precautions, condemn yourself as a person because they did not go well, or discount and deny how well they actually did go, the end result is a sense that your negative beliefs about yourself have indeed been confirmed. You were absolutely right – you *are* useless, inadequate, unlovable or whatever it may be. You may actually say this to yourself in so many words – ‘There you are, I always knew it, I am simply not good enough.’ Or confirmation of the Bottom Line may be reflected more in a feeling (sadness, despair) or a change in body state (a heaviness, a sinking in your stomach). Whatever the form confirmation takes, the essential message is that what you always knew about yourself has been proved yet again – you are indeed the person you always thought you were. And the process may not stop there.

Self-critical thoughts

The sense that your negative ideas about yourself have been confirmed often leads to a spate of self-critical thoughts. ‘Self-critical’ here does not mean a calm observation that you have done something less well than you wanted, or attracted a negative reaction from someone, followed by considering if there is anything constructive you might want to do to put things right. It means condemning yourself as a person. Self-critical thoughts may just flash briefly through your mind, before you turn your attention to something else. Or you may find yourself trapped in a spiralling sequence of attacks on yourself, perhaps in quite vicious terms. Here is what Jesse (the boy whose father quizzed him at the supper table) said to himself when his computer crashed and he lost an important document he was rushing to complete to deadline:

Now look what you've done. You are a complete and total idiot. How could you be so stupid? You always mess things up – absolutely typical. You'll never amount to anything – you simply haven't got what it takes. Why are you always so useless? Why can't you get anything right? You're a waste of space.

Something which was actually not at all his fault was taken by Jesse to confirm his negative ideas about himself. Because he assumed the crash was all down to something integral to his personality, it also seemed to him to have major implications for his future – it would always be this way. You can probably imagine the mixture of frustration and despair which Jesse experienced at that point, and how difficult it was for him to set about putting the situation calmly to rights.

Self-critical thoughts, like anxious predictions, have a major impact on how we feel and how we deal with our lives. They contribute to keeping low self-esteem going. Think about your own reactions when things go wrong or do not work out as you planned. What runs through your mind in these situations? Are you hard on yourself? Do you put yourself down and call yourself names, like Jesse? Learning to detect and answer your self-critical thoughts, and to find a more realistic and kindly perspective, is part of overcoming low self-esteem. Chapter 5 will focus in detail on how to do this.

The emotional impact of self-critical thoughts

When Jesse's computer crashed, he completely abandoned his project. He felt really down, completely fed up with himself. He just wanted to shut himself away and lick his wounds. He simply couldn't make himself get started again. He had been due to go away at the weekend with some friends, but he couldn't face it. He told everyone he was ill, and sat around at home doing nothing in particular. He couldn't even be bothered to watch television. With nothing else to occupy his mind, he began to brood about the future. He couldn't see any real prospect that things would change, so what was the point of carrying on?

Self-critical thinking affects mood. Consider this for yourself. How do you feel when you are putting yourself down or being hard on yourself? What effect does it have on your motivation to problem-solve and tackle difficulties you may have in your life? Being critical of yourself, especially if you believe that what you criticize in yourself is a permanent part of your make-up and cannot change, will pull you down into depression. This may be only a momentary sadness, swiftly banished by spending time with people you care about, or by engaging in an absorbing activity. Or it may develop and snowball – as Jesse's began to do – into a serious depression which may be quite hard to get out of. If this has become the case for you, you may need to address the depression in its own right before you begin to tackle low self-esteem (see Chapter 1 for information on how to recognize depression that might need treatment).

Whether the dip in mood is transitory, or whether it is difficult to shift, depression completes the vicious circle. We know from research into cognitive therapy that depression in itself has a direct impact on thinking. Once you become depressed, whatever the reason for your dip in mood, the depression itself will make you more likely to indulge in self-critical thinking, and to view the future with gloom and pessimism. So depression keeps the Bottom Line activated, and sets you up to continue to predict the worst. Bingo! You have a self-maintaining process which is quite capable of continuing to cycle, if you do not interrupt it, for long periods of time.

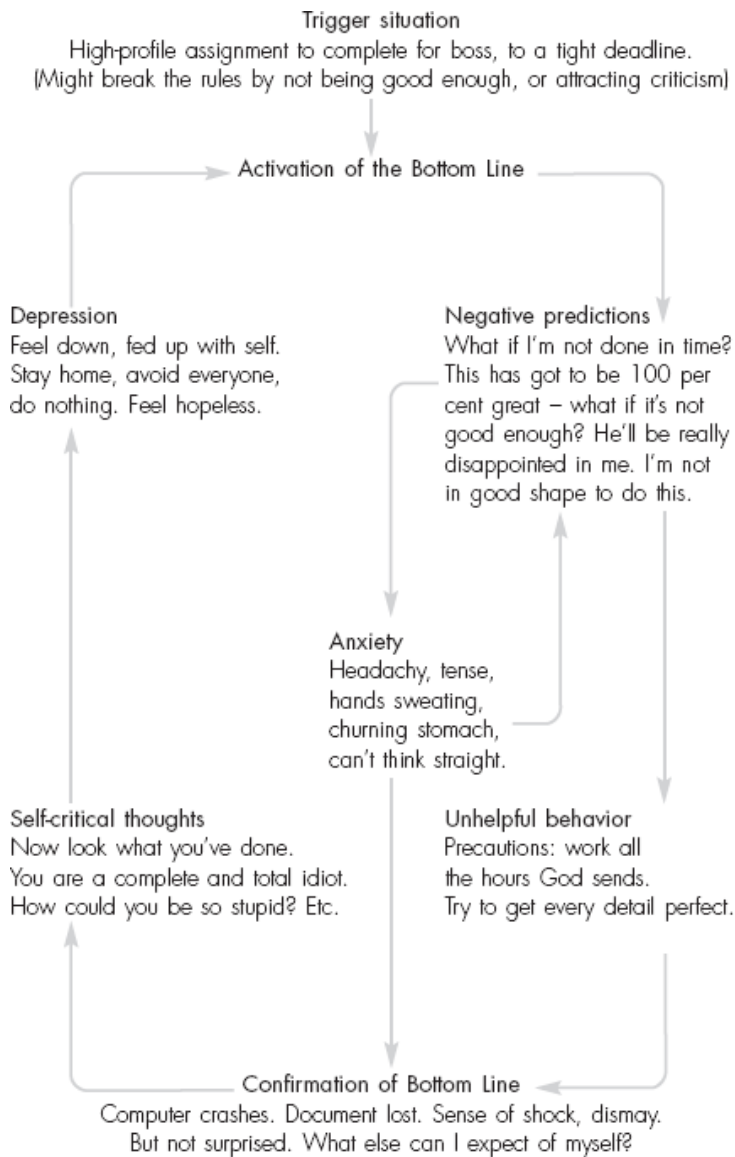
Mapping your own vicious circle

As you have made your way through this chapter, you have been asked from time to time to consider how you personally might react in particular situations, to reflect on your own anxious predictions and their impact on your emotional state and your behavior, your own sense that your negative beliefs about yourself have been confirmed, your own typical self-critical thoughts, and the impact these have on how you feel and how easy it is to manage your life to your own satisfaction. If you have not already done so, now is the chance to bring together your observations by drawing up your own vicious circle. As an illustrative example, you will find the circle Jesse drew up after his computer crashed on page 78.

Start by thinking of a type of situation in which you reliably feel anxious and uncertain about yourself. Now look for a specific recent example. Make sure you select something that is still fresh in your mind, so that you will be able to recall accurately how you felt and thought in the situation. Follow the circle through, using the headings in the flow chart on page 78, and noting your own personal experiences and reactions under each heading. If you wish, when you have completed one circle, start from a different anxiety-provoking situation and repeat the process. By doing so,

you are increasing your awareness of how your patterns of anxious and self-critical thinking operate to keep low self-esteem going. This is your first step to breaking the circle and moving on.

Figure 7 The vicious circle that keeps low self-esteem going: Jesse



Breaking the circle

In the chapters that follow, you will discover ways of breaking the vicious circle that keeps low self-esteem going. You will learn how to become aware of your own anxious predictions as they arise, how to question them, and how to test out their accuracy through direct experience, approaching situations you normally avoid and dropping unnecessary precautions, so that you can find out for yourself what is really going on. You will learn how to notice self-critical thinking and nip it in the bud, short-circuiting the development of depression. You will learn how to counter the bias against yourself by focusing on your skills, qualities, assets and strengths and by treating yourself to the good things in life. You will move on to changing the rules that make you vulnerable to entering the vicious circle when you break their terms, and finally you will pull together all the changes you have made and tackle your Bottom Line. Your objective throughout will be to overcome the low self-esteem that has been hampering your appreciation of yourself and your ability to enjoy your life to the full, and to develop and strengthen a new, more kindly and helpful perspective.

CHAPTER SUMMARY

- 1 The Bottom Line at the heart of low self-esteem comes to life in situations where it appears your Rules for Living might be broken. Once activated, it triggers the vicious circle which keeps low self-esteem going in the present day.
- 2 Uncertainty and self-doubt then lead to negative predictions – anticipating the worst and assuming there is little or nothing you can do to prevent it.
- 3 Negative predictions produce anxiety, with all its physical signs and symptoms (the body's normal response to threat).
- 4 They also affect behavior, leading to complete avoidance, adopting unnecessary precautions, or genuine disruptions in performance. Even if things go well, the prejudice against yourself makes it difficult to recognize or accept this.
- 5 The end result is a sense that your Bottom Line has been confirmed.
- 6 Confirmation then triggers self-critical thinking.
- 7 Self-critical thinking in turn often leads to a dip in mood, which may develop into a full-blown depression.
- 8 Low mood ensures the continued activation of the Bottom Line, thus completing the circle.

PART THREE

Overcoming Low Self-Esteem

Checking out anxious predictions

Introduction

In a manner of speaking, people are like scientists. We make predictions (e.g. 'If I press this switch, the light will come on', 'If I stand in the rain, I will get wet', 'If I have too much to drink, I will have a hangover') and we act on them. We use information from what happens to us, and from what we do, to confirm our predictions or to change them. This system of acting on predictions (many of which may be so much a part of how we operate that we do not even put them into words) is generally a useful one, provided that we keep an open mind, are receptive to new information and remain willing to change our predictions in the light of experience and in response to variations in circumstances (e.g., sticking with the light-switch prediction could cause some frustration, in the event of a power cut).

Low self-esteem makes it hard to make realistic predictions, or to act on them with an open mind. When people with low self-esteem make predictions about themselves (e.g. 'I won't be able to cope', 'Everyone will think I'm an idiot', 'If I show my feelings, they will reject me'), they tend to treat them as facts, rather than as hunches which may or may not be correct. So it is difficult to stand back and look at the evidence objectively, or to remain open to experiences which suggest the predictions do not fit the facts. What's the point? The result is a foregone conclusion.

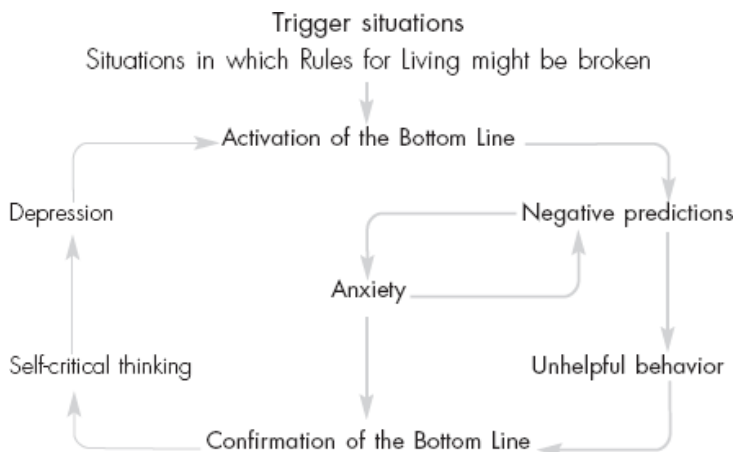
In low self-esteem, anxious predictions arise in situations where the Bottom Line has been activated because there is a chance that personal Rules for Living might be broken. (If you are absolutely 100 per cent sure that your rule *has* been broken, then you will miss anxiety and head straight for the sense that your Bottom Line has been confirmed, self-criticism and depression.) If it is not clear whether a rule will actually be broken or not and there is an element of uncertainty or doubt, the consequence will usually be anxiety.

Doubt and uncertainty lead a person to wonder what is going to happen next. Will I be able to cope? Will people like me? Will I make a hash of this? The answers to these questions – predictions about what is about to go wrong – spark anxiety, and lead to a whole range of strategies designed to prevent the worst from happening. Unfortunately, in the long run, these strategies rarely work. The end result, however the doubt is resolved in reality, is a sense that the Bottom Line has been confirmed or, at best, that confirmation has been narrowly escaped.

In this chapter, you will learn how to break the vicious circle that keeps low self-esteem going by identifying your own anxious predictions, questioning their validity and checking them out for yourself by approaching situations you might normally avoid and dropping unnecessary precautions. This is the part of the vicious circle that

we shall be addressing:

Figure 8 The vicious circle: The role of anxious predictions in keeping low self-esteem going



Situations that trigger anxiety

Think back to the people you met in Chapters 2 and 3. On page 63 was a list of the kind of situations which activated their Bottom Lines. You will see from these examples that, in each case, these are situations where self-protective rules might be broken. And, in each case, there is an element of uncertainty or doubt. Briony's true (bad) self *might* be exposed – but she is not sure. Jesse *might* not be able to meet his high standards – but he is not certain. Karen *suspects* before she goes shopping that her body shape will not be as it should, for her to feel good about herself – but, as yet, she has no concrete evidence.

This element of doubt is central to the experience of anxiety. It creates a vacuum, which we fill with dreadful imaginings – predictions about what we most fear might happen. We may be aware with a part of our minds that the worst is very unlikely, or even that we would be able to deal with it, should it occur – but we are not convinced and, the more anxious we feel, the less convinced we are.

How anxious thinking works

Anxious predictions result from the sense that we are about to break rules which are important to our sense of self-esteem. Chapter 7 focuses on ways of changing and adapting Rules for Living in their own right. But first, you will learn how to break the vicious circle that keeps low self-esteem going by identifying and changing the predictions that make you anxious in everyday situations.

Anxious predictions usually contain biases which feed into the sense of uncertainty and dread. These are:

Overestimating the chances that something bad will happen

When we find ourselves in situations where adherence to our particular rules is under threat, the likelihood that something will go wrong is much inflated in our minds. Let us take Kate as an example. You may remember that Kate's parents had difficulty in expressing their affection for her. Her Bottom Line was that she was unlovable, and her Rules for Living were that if she failed to meet others' expectations she would be rejected, and that if she ever asked for her needs to be met she would be disappointed. Kate worked in a hairdresser's. She and her colleagues took it in turns to go out and buy the lunchtime sandwiches. One day, when it was her turn, her boss forgot to pay her back for his sandwich. Kate felt completely unable to ask for what she was owed. She was convinced that, if she did so, her boss would despise her and think she was mean. This was despite the fact that she knew from months of working for him that he was a kind, thoughtful man who was careful of his employees' welfare. She took no account of the evidence, which suggested that in fact he was likely to be embarrassed, apologize and immediately give her what she was entitled to.

Overestimating how bad it will be if something bad does happen

Not only is it likely that bad things will happen, but when they do, they will be very bad. Anxious predictions rarely assume that, if something bad does happen, it will be a momentary inconvenience, quickly over, after which life will go on. At the heart of anxious predictions is the notion that the worst possible thing will happen and that, when it does, it will be on the scale of a personal disaster.

So Kate, for example, when she looked ahead, could not see her boss being mildly inconvenienced by having to pay her back, and then quickly forgetting all about it. She assumed that asking for what was owed her would permanently change their relationship. He would never look at her in the same way again, and she would probably need to find another job – which would be difficult, because he would not want to give her a reference, and she might get a reputation as someone with a tendency to cause personality clashes and find it difficult to get another job of any sort. Then she would not be able to live independently, but would have to go back to her parents and live on state benefit and would be completely stuck. Kate could clearly see all this happening, in her mind's eye.

You can see here how what, to an outside observer, might seem a trivial event (asking for money for a single sandwich), for Kate leads into a whole saga unfolding, each step worse than the last. This kind of sequence is typical of anxious thinking.

Underestimating personal resources to deal with the worst, should it happen

When people are anxious they are apt to think that, if the worst should happen, there will be nothing they can do to prevent it or make it manageable. Kate assumed that, no matter what she did, her boss's reaction would be completely rejecting. It did not occur to her that she could stand up to her boss, if he did indeed respond as she predicted, by reminding him assertively that she was entitled to get her money back. Nor did she take account of her professional skill and experience, which in fact made it very likely that she would find other employment quite easily.

Underestimating outside resources

In addition to underestimating their own personal resources, people making anxious predictions tend to underestimate things outside themselves that might improve the situation or even defuse it entirely. Kate, for example, forgot the support she would get from her colleagues, friends and family if her boss reacted so unreasonably.

Taking precautions: Unnecessary self-protection

Put together, these biases in thinking constitute a perfect recipe for fear. They give you a strong sense that you are at risk – of failure, of rejection, of losing control, of making a fool of yourself. In short, of breaking the rules. So, like any sensible person facing a threat, you take precautions to protect yourself, to stop the worst from happening. Unfortunately, the precautions you take, far from improving things, actually prevent you from discovering for real whether your anxious predictions have any true foundation and so keep low self-esteem going.

It will not be possible for you to discover whether or not your anxious predictions have any basis in reality, unless you drop the precautions you have been taking to ensure that they do not come true. That is the only way to discover if your ideas are correct – if the precautions are not dropped, you will always have a sneaking feeling that you had a narrow escape, and will never really be certain whether your thinking was biased or not.

An example may help to make this point. Imagine you go for a meal at the house of Vladimir, an old friend. As soon as you come in, you notice a powerful smell. Could it be something to do with the cooking? With your pre-dinner drinks, you have garlic croutons and a garlic dip. The first course is garlic soup, with garlic bread. This is followed by roast lamb with whole garlic cloves, and salad with a garlic dressing. For dessert, garlic ice cream (surprisingly interesting) and, to conclude, a creamy French cheese with herbs and – you've guessed it – garlic. As the evening progresses, you become gradually aware that the room is hung with wreaths and garlands of garlic. Finally, curiosity wins out over politeness.

'What's with all this garlic?' you ask.

'Ah!', replies Vladimir. 'I was hoping you wouldn't notice.'

I didn't want you worrying.'

'Worrying?'

'Well, yes. It's the vampires, you see. I didn't want you worrying about the vampires.'

'The vampires?'

'Yes. I think we've got enough garlic to keep them away, though,' says Vladimir reassuringly.

'But there aren't any vampires,' you protest.

'Exactly!' says Vladimir smugly.

The strategies people employ to prevent their worst fears from coming true are like Vladimir's garlic. It seems to him that the only reason the house is not overrun with vampires is that it is full of garlic. He could, of course, be right: though a review of available evidence might suggest that his fears are exaggerated. In order to discover that the danger is more apparent than real, he would have to abandon this self-protective strategy and get rid of all the garlic. Given the strength of his belief in vampires, this might be quite difficult for him to do. He might need to do it one step (or clove) at a time. Or, if he were able to consider the evidence coolly, he might be

prepared to go the whole hog and rid the house of garlic entirely. Only then could he discover that his fears are unfounded – he is actually quite safe.

How to identify anxious predictions and spot unnecessary precautions

The first steps towards achieving a more balanced view of what is really likely to happen in situations you fear are: first, to become aware of what you are predicting when you become anxious; and, second, to notice the precautions you take to stop your predictions coming true. This means learning how to tune into anxiety or apprehension as soon as it happens, noticing what is running through your mind when the feeling starts, and spotting what you do to protect yourself. This information will provide you with a basis for change – rethinking your predictions and checking out their validity by doing the things you are afraid of without taking unnecessary precautions.

On page 92, you will find a blank record sheet which you can use to make your own record of anxious predictions and the steps you take to avert disaster (the 'Predictions and Precautions Record Sheet'; there are further blank copies provided in the Appendix). Kate's dilemma is illustrated as an example on page 93, to give you a sense of what you are aiming at.

Figure 9 PREDICTIONS AND PRECAUTIONS RECORD SHEET

Date/Time	Situation What were you doing when you began to feel anxious?	Emotions and body sensations (e.g. anxious, panicky, tense, heart racing) Rate 0–100 for intensity	Anxious predictions What exactly was going through your mind when you began to feel anxious? (e.g. thoughts in words, images) Rate 0–100% for degree of belief	Precautions What did you do to stop your predictions coming true? (e.g. avoid the situation, safety-seeking behaviors)

Figure 10 PREDICTIONS AND PRECAUTIONS RECORD SHEET: KATE

Date/Time	Situation What were you doing when you began to feel anxious?	Emotions and body sensations (e.g. anxious, panicky, tense, heart racing) Rate 0–100 for intensity	Anxious predictions What exactly was going through your mind when you began to feel anxious? (e.g. thoughts in words, images) Rate 0–100% for degree of belief	Precautions What did you do to stop your predictions coming true? (e.g. avoid the situation, safety-seeking behaviors)
6.2.2009	<i>Bought sandwich for Ian for lunch. He forgot to pay me back.</i>	Anxious 85 Embarrassed 80 Heart racing 90 Sweaty 70 Hot 90	<i>If I ask for the money, he will think I'm really mean 90% It will spoil our relationship for ever 80% I will have to find another job 70% I won't be able to 70% I'll be stuck at home with no money 70%</i>	<i>Avoid him altogether If I did ask, I would: Be very apologetic Not look at him directly Keep my voice down Tell him it didn't really matter Get it over and done with as fast as possible and then run away</i>

The main benefit of using a structured record sheet like this, rather than simply keeping a day-to-day diary of things that come up, is that it will encourage you to follow things through in a systematic way. The headings will remind you of what you should be looking out for, and later what steps you need to take to change things for the better. In contrast, simply keeping a narrative diary may result in you getting lost in your fears, especially if your low self-esteem has been in place for some time and anxious predictions have become a habit that is hard to break. If you *do* prefer to use

your own form of diary, then at least structure your investigations by following the headings on the suggested record sheet.

If at all possible, make your record at the time you actually experience the anxiety. This is because it is often difficult to tune into anxious predictions when you are not actually feeling anxious. Even if you can work out what they are, they may seem ridiculous or exaggerated when you are not in the situation, and so it will be difficult to accept how far you believed them and how anxious you felt at the time. The steps involved are these:

Date and time

Make a note of when you experienced anxiety. This information may help you to spot patterns from day to day. If, for example, your rules relate to competence and achievement, then you may notice peaks in anxiety as you arrive at work. If, on the other hand, your doubts relate to how acceptable you are to others, then you may find your worst time is weekends, when you are expected to socialize.

The situation

What was going on when you started to feel anxious? What were you doing? Who were you with? What was happening?

It could be that the situation that activated your Bottom Line was an outside event (for example, having to answer a difficult question in front of colleagues, or receiving a bill through the post). Or it could be something inside yourself (for example, remembering a time in the past when you felt embarrassed and humiliated, thinking about a task that you have been putting off, or noticing that your palms are sweating when you are about to shake hands).

Your feelings

Changes in your anxiety level are a signal telling you that you are making anxious predictions. Make a note of the emotion you experienced. Was it apprehension? Fear? Anxiety? Panic? Look out for other emotions, too – for example, feeling pressurized, worried, frustrated, irritable or impatient. Rate each emotion between 0 and 100, according to how strong it is. One hundred would mean it was as strong as it could possibly be, 50 would mean it was moderately strong, 5 would mean there was just a hint of emotion, and so on. You could be anywhere between 0 and 100. The idea of rating the intensity of your emotions, rather than just noting that they were present, is that when you come to work on changing your anxious predictions, you will be able to pick up small changes in your emotional state which you might otherwise miss.

Body sensations

Anxiety normally goes along with a whole range of body sensations. These vary to some extent from person to person. They are reflected in the sayings we commonly use to describe anxiety – ‘uptight’, ‘shaking like a leaf’, ‘on edge’, ‘white as a sheet’, ‘sick with fear’, and so on. They include:

- Increases in muscle tension (for example, in your jaw, forehead, shoulders or hands). Many people have a 'favourite' tension site in the body. Where is yours?
- Changes in heart rate (for example, your heart speeds up, pounds heavily or seems to miss a beat)
- Changes in breathing (you may notice you are holding your breath, breathing faster or breathing unevenly)
- Mental changes (for example, it may become hard to focus on what is going on, your mind may go blank, or you may feel muddled and confused)
- Changes in the gastric system (e.g. churning stomach, 'butterflies', needing to go to the toilet repeatedly)
- Other physical symptoms like shakiness, sweating, a sense of weakness, feeling dizzy or faint, numbness or tingling sensations, changes in vision (for example, blurring or tunnel vision).

All of these are in fact part of the body's normal built-in response to threat. To some extent, they are actually helpful – for performers such as musicians or athletes, for example, being keyed up gives an edge to their performance. The physical symptoms of anxiety are signs that glands near the kidneys are releasing adrenalin, a hormone that prepares the body for 'fight or flight' – that is, to confront and tackle the danger that threatens, or to run away from it. Your anxious predictions are telling your body that it needs to go on red alert. Once you become skilled at defusing the predictions, your body will stop responding in this way. In the meantime, it will be helpful to notice your own particular bodily reactions to anxiety, not least because (as we said in Chapter 3) these reactions can in themselves give rise to further anxious predictions – for example, 'Everyone will notice how nervous I am and think I'm weird', 'If this goes on, I'm going to crack up', or 'I can't possibly cope with this situation, feeling as I do'. Naturally enough, these extra predictions are likely to intensify the anxiety, forming a mini-vicious circle that contributes to keeping the problem going.

So make a note of your body sensations, and rate them between 0 and 100, according to how strong they are, just as you rated the intensity of your emotions. And watch out for any extra predictions you make, based on how you are feeling. You can record them in the next column.

Your anxious predictions

What was going through your mind just before you began to feel anxious? And as your anxiety built up? The thoughts you are looking for will be concerned with the future – with what is about to happen. They will, in effect, be your predictions about what is going to go wrong, or is already going wrong. Write them down, word for word, just as they occur to you. Then rate each one between 0 and 100 per cent, according to how strongly you believe it. One hundred per cent means you are fully convinced, with no shadow of doubt; 50 means you are in two minds; 5 means you think there is a remote possibility; and so on. Again, you could be anywhere between 0 and 100 per cent. Generally speaking, you are likely to find that the more strongly you believe your predictions, the more anxious you feel. And, of course, the reverse is also true – the more anxious you feel, the more likely you are to be convinced by your predictions and to behave accordingly, taking steps to protect yourself that are in fact unnecessary and unhelpful.

You may find that your thoughts do not take the form of identifiable predictions, You may experience images in your mind's eye instead. These may be snapshots or

freeze frames, or they may take the form of movies – a stream of events following on from one another – like Kate’s fears about her boss’s reaction and what would follow from that. These images and sequences may be very vivid and therefore highly convincing. They usually illustrate what a person fears may happen. That is, they are like a visual version of your worst fears – your anxious predictions. Describe them as clearly as you can, identify the predictions they contain, and rate how far you believe each one (0–100 per cent).

Alternatively, you may find that your thoughts do not take the form of explicit predictions, but rather of short exclamations like ‘Oh my god!’, or ‘Here I go again!’. If this is the case, write the exclamation down, and then spend some time considering what it may mean. What is the prediction concealed in the exclamation? If you unpack the meaning behind the explanation, the level of anxiety you are experiencing will make sense. Ask yourself: what might be about to happen? What is the worst that could happen? And then what? And then what? ‘Here I go again’ – well, where? Again, write the hidden predictions down, and rate how far you believe each one (0–100 per cent).

Finally, your prediction may be concealed in a question, such as, ‘Will they like me?’ or ‘Supposing I can’t cope?’ or ‘What if everything that goes wrong?’ Many anxious thoughts take the form of questions, which makes sense when we consider that they are a response to uncertainty or doubt. To find the hidden prediction, ask yourself: what is the answer to this question which would account for the anxiety I am experiencing? For example, if your question is ‘Will they like me?’, the hidden negative prediction is likely to be ‘They won’t like me’. You could believe this fairly strongly, or hardly at all, or somewhere in the middle.

The precautions you take to prevent your predictions from becoming true

When one is faced with a genuine threat, it makes perfect sense to take steps to prevent it from causing harm. The threat you are facing may be more apparent than real, once you come to stand back and take a good look at it, but for the moment it seems real enough. So what do you do to protect yourself from it? What steps do you take to ensure that it does not come to pass? Complete your record by writing down the precautions you take, in as much detail as you can.

In particular, look out for:

- Complete avoidance (for example, Kate said nothing to her boss for several days and avoided spending any time with him at all)
- Entering the situation you fear, but setting things up so as to protect yourself from what you think might happen.

Technically, such precautions are called safety-seeking behaviors, precisely because they are things we do to keep ourselves safe and protect ourselves from breaking our rules. Complete avoidance is usually relatively easy to spot. Safety-seeking behaviors may be less obvious. Sometimes they are quite subtle – you may not be fully aware of them at all. This calls for careful observation of yourself, which you can do best if you experiment with entering situations you fear and watching out for how you keep yourself safe in those situations. You can do this in your imagination, too. Kate, for example, did not at first feel ready to approach her boss at all. But she could imagine

how she would operate if she was able to screw up her courage to the point of asking for her money back. She saw herself avoiding eye contact, apologizing profusely, telling him it didn't really matter, speaking quietly and hesitantly, and rushing to get the encounter over as quickly as possible. Before speaking at all, she would rehearse numerous times exactly what to say, trying to make sure that she made her request in the most inoffensive way.

Keep your record for a few days or a week, making a note of as many examples as you can. By the end of that time, you should have a pretty good idea of the situations in which you feel anxious, the predictions that spark off your anxiety, and the precautions you take to prevent the worst from happening. This is your basis for beginning to question your anxious predictions, and to check them out by dropping unnecessary precautions and finding out for yourself whether what you fear is really likely to happen.

Checking out anxious predictions

Anxious predictions are unhelpful. Far from preparing you to deal effectively with daily life, they make you feel bad and lead you to waste energy on taking precautions that only serve to keep the vicious circle of low self-esteem going. So changing them has a number of benefits: it makes you feel better, gives you an improved chance of approaching life with confidence and enjoying your experiences, and encourages you to experiment with being your true self.

Two main steps are involved in checking out anxious predictions:

- 1 questioning them so as to arrive at more realistic and helpful alternatives, and
- 2 testing new perspectives out in practice by approaching (instead of avoiding) the situations you fear, and dropping your safety-seeking behaviors.

Figure 12 CHECKING OUT ANXIOUS PREDICTIONS RECORD SHEET – EXAMPLE: KATE

Date/ Time	Situation	Emotions and body sensations Rate intensity 0–100	Anxious predictions Rate belief 0–100%	Alternative perspectives Use the key questions to find other views of the situation. Rate relief 0–100%	Experiment 1 What did you do instead of taking your usual precautions? 2 What were the results?
20.2.09	Ask Ian for money he owes me	Anxious 95 Embarrassed 95 Heart pounding 95 Feeling hot and red 100	He will shout at me 90% He'll think I'm really mean 90% It will spoil our relationship 80% I will have to find another job 80% I won't be able to 70% I'll be stuck at home with no money 70%	There's no evidence he'll react like that. What I know of him shows he's not that kind of person 100% He might be a bit annoyed, but it would pass and he'd be thinking of something else two minutes later 95% Even if he did react like that, everyone would support me. I would if it was someone else. I would think they were entitled to what they were owed 100% Maybe I'm entitled too 30% Even if I did lose my job, I'm a good enough hair- dresser to find another 60% I could be making a moun- tain out of a molehill here 50%	1 Ask him. Don't apolo- gize or say it doesn't matter. Be polite and pleasant, but firm. Take your time. 2 He gave it to me right away! He said he was sorry, he'd just forgotten. No sign afterwards that he thought anything of it. I learned that if I take the risk, I can get what I want, even if it does make me nervous.

This may seem like rather a daunting prospect. However, you will find that discovering alternatives to your predictions will help you to feel less fearful about going into what now seem like risky situations and to drop self-protective strategies. This is important: if you do not change how you operate when you feel yourself to be under threat, you will never feel fully confident that the new perspectives you discover are genuinely reality-based, rather than rationalizations with no real truth.

Finding alternatives to anxious predictions

The best way to construct a more helpful and realistic perspective on situations that make you anxious is to learn to stand back and question your predictions, rather than accepting them as fact. You can use the questions summarized in the table on page 105, to help you to discover more helpful and realistic perspectives and tackle the biases in thinking that contribute to anxiety. Each time you find an answer or alternative to your anxious predictions, write it down and rate how far you believe it (0–100 per cent). You may well not believe your alternatives fully at the moment, but you should at least be prepared to accept that they might theoretically be true. Once you have a chance to test them out in practice, you will find your degree of belief will increase.

You may find it helpful to write down your alternatives on copies of the record sheet you will find on page 102 ('Checking Out Anxious Predictions Record Sheet'; additional blank copies are provided in the Appendix). A completed sheet, using Kate as an example, is on page 103. Again, a structured record sheet may be more helpful than a narrative diary because it will help you to follow things through in a systematic way rather than getting stuck in your fears.

Figure 13 Key questions to help you find alternatives to anxious predictions

- What is the evidence to support what I am predicting?
- What is the evidence against what I am predicting?
- What alternative views are there? What evidence is there to support them?
- What is the worst that can happen?
- What is the best that can happen?
- Realistically, what is most likely to happen?
- If the worst happens, what could be done about it?

Key questions to help you find alternatives to anxious predictions

What is the evidence to support what I am predicting?

What makes you think what you do? What are you going on when you anticipate the worst? Are there experiences in the past (maybe even very early in your life) that have led you to expect disaster in the present day? Or is your main evidence simply your own feelings? Or the fact that in this sort of situation, you always expect things to go wrong – it's a habit?

What is the evidence against what I am predicting?

Stand back and take a broader view. What are the actual facts of the current situation? Do they support what you think, or do they contradict it? In particular, can you find any evidence which does *not* fit your predictions? Is there anything you have not been attending to which would suggest that your fears may be exaggerated? Are there any rescue factors you have been ignoring? Any resources in yourself that you have been putting to one side? Any indications from past or current experience that would suggest things may not go as badly as you fear?

The temptation with anxious predictions is to assume the worst – to jump to conclusions. Instead, stick to the facts.

What alternative views are there? What evidence is there to support them?

Are you falling into the trap of assuming that your view of things is the only one possible? There are always many ways of thinking about an experience. A mistake, for example, may seem to a person with low self-esteem to be a disaster or a sign of failure. But to another person, it might seem like a minor inconvenience, or an understandable result of normal human imperfection, or a product of tiredness or of a moment's inattention which simply needs correction, or even a valuable opportunity to learn and to extend one's knowledge and skill.

Consider the situation you are facing at the moment. What would your view of it be, for example, if you were feeling less anxious and more confident? What might another person make of it? What would you say to a friend of yours who came to you with the same concern – would your predictions be different? Are you exaggerating the importance of the event? Assuming it will have lasting repercussions if things do not work out as you wish they would? What will your perspective be on this event after a week? A month? A year? Ten years? Will anyone even remember what happened? Will you? If so, will you still feel the same about it? Probably not.

Write down the alternative perspectives you have found, and then make sure you review the evidence for and against them, just as you reviewed the evidence for and against your original predictions. An alternative which does not fit the facts will not be helpful to you, so make sure your alternatives have at least some basis in reality.

What is the worst that can happen?

This question is particularly useful in dealing with anxious predictions. Making your predicted 'worst' explicit allows you to get a clear take on it, and can be helpful in a number of ways. Once you have put the worst down in black and white, you may immediately see that what you fear is so exaggerated as to be impossible. Kate, for example, had a flash in her mind's eye of her boss having a major tantrum in the middle of the salon and throwing her out. In reality, there was no way that he would behave so unprofessionally in front of all his clients and staff, however he felt about her request.

Look for whatever information you need to obtain a more realistic estimate of the true likelihood of what you fear occurring. Even if it is not impossible, it may be much less likely to happen than you predict. Additionally, there may be things you can do to reduce the likelihood of the worst happening, in just the same way that you might have the wiring checked and buy smoke alarms and a fire extinguisher when you move into a new house.

What is the best that can happen?

This is a counterbalance to the previous question. Try to think of an answer which is just as positive as your worst is negative. You may notice, incidentally, that you are less inclined to believe in the best than you were to believe in the worst. Why? Could it be that your thinking is biased in some way?

Kate called up an image of her boss congratulating her in front of everyone for standing up for herself, rushing out to buy her flowers and chocolates, and insisting on giving her an immediate pay rise and a promotion. Creating this unlikely vision helped her to see how exaggerated her fears were, too.

Realistically, what is most likely to happen?

Look at the best and worst you have identified. Realistically, what is most likely to happen is probably somewhere in between. See if you can work out what it might be.

If the worst happens, what could be done about it?

Once you have worked out what the worst is, you can plan how best to deal with it. And once you have worked out how to deal with the worst, anything else is a piece of cake. Remember, anxious predictions underestimate the resources likely to be available to you in difficult situations. Even if what you fear is quite likely, it is possible that you would in fact be better able to cope with it than you have automatically assumed, and that there would be resources available (including the goodwill and assets of other people) to help you to do so. Consider:

- What personal assets and skills do you have that would help you to deal with the worst if it arose?
- What past experience do you have of successfully dealing with other, similar threats?
- What help, advice and support are available to you from other people?
- What information could you get that would help you to gain a full picture of what is going on and deal more effectively with the situation? Who could you ask? What other sources of information are open to you (e.g. books, the media, the Internet)?
- What can you do to change the situation itself? If the situation that makes you anxious is genuinely unsatisfactory in some way, what changes do you need to make? Perhaps someone's unreasonable expectations of you need to change, or you need to begin doing more for yourself, or to organize extra help and support. You may well find that such changes are blocked by further negative predictions (e.g. 'But they'll be angry with me') or by self-critical thoughts (e.g. 'But I should be able to cope alone'). If so, make a note of these thoughts and search for alternatives to them. They, too, can be questioned and tested out. And even if the situation cannot be changed, or is not really the source of the problem, then you can still learn to change your thoughts and feelings about it – and, indeed, that is what you are doing right now.

Checking out anxious predictions in practice

Discovering alternatives to anxious predictions is often helpful in itself. You may well find that, as your focus clears, you begin to feel less fearful of the catastrophic consequences of breaking your rules. However, questioning your thoughts may not be enough in itself to convince you that things are not as bad as they seem. You need to act differently, too, to learn how things really are through direct experience. Experimenting with new ways of doing things (for example, being more outgoing and assertive, taking the risk of being yourself with other people or accepting challenges and opportunities you would previously have avoided) allows you to build up a body of experience that contradicts your original predictions and supports new perspectives.

Experiments provide a direct test of what you think, a chance to fine-tune your answers in the real world, to break old habits of thinking and strengthen new ones. They give you an opportunity to find out for yourself whether the alternatives you have thought up are in line with the facts, and therefore helpful to you, or whether you need to think again. But this will only happen if you take the risk of entering situations you have been avoiding, and drop the precautions you have been taking to

keep yourself safe. Experiments will help you to weed out alternative ways of thinking that do not work for you, and to strengthen and elaborate those that do. Without them, your new ideas are largely theoretical. With them, you will know on a gut level what the reality is. We shall return to the idea of experiments repeatedly throughout this book.

How to set up experiments: Acting to check out anxious predictions

You have learned to identify your anxious predictions, their impact on your feelings and body state, and the precautions you take to ensure that they do not come true. You have moved on to begin to question your predictions, examining the evidence and searching for alternative perspectives that may be more realistic and helpful. You can use these skills as a basis for setting up experiments to check out for yourself whether your predictions are accurate. You can do this quite deliberately (for example, planning and carrying out one experiment every day), and you can also use situations that arise without you planning them (e.g. an unexpected phone call or an invitation) to practise acting differently and observing the outcome, using the final column of the record sheet on page 102.

These are the steps involved.

1 State your prediction clearly

Make sure that what you fear might happen is very clearly and explicitly stated (you have already learned to tune in to anxious predictions). Experiments are most useful when they are designed to test out specific troublesome predictions. If your predictions are vague, it will be difficult to ascertain whether or not they have come true. So write down exactly what you expect to happen, including, if relevant, how you think you and other people will react, and rate each prediction according to how strongly you believe it (0–100 per cent). For example, if you are predicting that you will feel bad, rate in advance how bad you think you will feel (0–100), and in what way. Many people find that, to their surprise, they do indeed feel anxious (for example), but not as much as they expected, especially once they get over the initial hurdle of entering the feared situation. Your rating will give you a chance to find out if this is true for you.

Again, your prediction may involve others' reactions. Perhaps you think that if you behave in a given way, people will lose interest in you, or disapprove of you. If so, work out how you would know this was happening. What would they say or do that would be a signal that they were indeed losing interest or disapproving? Include small signs like changes of facial expression, and shifts in direction of gaze. Once you have defined how you would know that what you fear is happening, you will know exactly what to look for when you go into the situation.

2 What will you do instead of taking precautions to ensure that the predictions do not come true?

Again, you will be aware from your record-keeping what precautions you normally take to keep yourself safe. If you continue to do so, you will not be able to find out if your predictions are true or not. Even if your experiment seems to turn out well, you

will be left with the sense that you have had a 'near miss'. So be as clear as you can here. Think of all the things you might be tempted to do to protect yourself, no matter how small. Work out in advance what you will do instead. For example, if your normal pattern when you talk to someone is to avoid eye contact and say as little as possible about yourself, in case people discover how boring you are, your new pattern might be to look at people (how else, apart from anything, will you have the remotest idea what they think?) and talk as much about yourself as they do about themselves. If your normal pattern at work is to have an answer to every question and never admit to ignorance, in case people think you are not up to the job, you could practise saying 'I don't know' and 'I have no opinion on that'. If your normal pattern is to hide your feelings, because to show them at all could lead you to lose control, you might experiment with being a little more open with someone you trust, about something that has annoyed or upset you, or with showing affection more overtly than you normally would.

3 What were the results of your experiment?

Whatever the nature of your experiment, it will be crucial to observe the consequences of acting differently so that, if your worst fears do turn out to be incorrect, you will be in a position to come up with more accurate predictions in similar situations in the future. To make sure you always make the most of any experiment you carry out, always review your results afterwards. What did you learn? What impact did acting differently have on how you felt? How far was what happened consistent with your original predictions, and with the alternatives you found? What implications does what actually happened have for your negative view of yourself? Does it fit? Or does it suggest that you could afford to think more positively of yourself?

In terms of outcome, there are two broad possibilities. Both are useful to you as sources of information about what is keeping your low self-esteem going. On the one hand, experience may show that your anxious predictions were *not* correct, and that the alternatives you found were indeed more realistic and helpful: so much the better. On the other hand, sometimes experience shows anxious predictions to be absolutely spot on. If so, do not despair. This is valuable information. How did this come about? Was it in fact anything to do with you, or some other element of the situation? What other explanations might there be for what went wrong, besides you? If you did contribute in some way to what happened, is there any way you could handle the situation differently in future, so as to bring about a different result? For example, are you sure you dropped *all* your safety-seeking behaviors?

Be honest! Look back over what happened and scrutinize yourself carefully. If some precautions were still in place, what do you think might have happened if you had dropped them (anxious predictions)? How could you check this out? Exactly what changes do you still need to make to your behavior? How will you ensure that you drop your safety-seeking behaviors completely, next time?

When you have carefully thought through what happened, work out what experiments you need to carry out next, using the same steps described above. How could you apply what you have learned in other situations? What further action do you need to take? Should you repeat the same experiment to build your confidence in the results? Or should you move on to try similar changes in a new and perhaps more

challenging situation? What's the next step?

Whatever the outcome of your experiment, congratulate yourself for what you did. Giving yourself credit for facing challenges and things that involve an effort is part of learning to accept and value yourself – part of enhancing self-esteem. What does what happened tell you about yourself, other people and how the world works? Given what has happened, what predictions would make better sense next time you tackle this type of situation? What general strategies could you adopt, based on what happened here, that will help you to deal even more effectively with similar situations in future?

An example: Kate goes shopping

Kate needed to buy a new washing machine. She had successfully experimented with asking her boss for the money he owed her, and discovered that her predictions were not accurate. However, she was still doubtful about her ability to ask effectively for what she needed. She predicted that if she took the time to enquire fully about the options available, and did not immediately understand the technological detail, the shop assistant would be impatient and would not respect her. She would know this because the assistant would use a snappy tone of voice, would leave her for another customer, and would make faces at other assistants. Her usual self-protective strategy in this kind of situation was to pretend to understand, only look at one or two models, and be effusively apologetic about taking the assistant's time.

She decided instead to ask as many questions as she needed in order to be clear about what her options were, to look at models right across the price range, and to be pleasant and friendly but not apologetic at all. After rethinking the prediction in advance, she came to the conclusion that although the reaction she feared might happen, it was unlikely, and might say more about the assistant than about her. This gave her the courage to have a go.

To her dismay, in the first shop she tried, the assistant behaved almost exactly as she had predicted. He was dismissive, kept turning to talk to other people, and did not seem to care whether she bought a machine or not. Fortunately, she had an opportunity that evening to talk over what had happened with a friend. The friend said that she had had much the same experience in the same shop, and recommended trying another with a better record of customer service. This allowed Kate to understand what had happened in a new way, rather than simply assuming that her original predictions must be correct. It restored her morale enough to have another go.

She discovered that it was possible to follow through her new, more assertive strategy without penalty. She asked lots of questions, asked the assistant to repeat himself a number of times, looked at a whole range of models, and in the end did not buy anything. The assistant treated her with courtesy, invited her to telephone if she had any further queries, and gave her his card. Further experiments on the same lines in other shops confirmed this new experience. Kate's conclusion was: 'I am entitled to take as long as I want to make a decision to spend my money. Asking questions and showing ignorance is OK – how else am I to find out what I need to know? If people are rude, that's their problem – it doesn't say anything about me.'

CHAPTER SUMMARY

- 1 In situations where personal Rules for Living related to low self-esteem may be broken, the Bottom Line is activated and triggers predictions about what might go wrong.
- 2 Such predictions are coloured by biases in thinking: overestimating the chances that something will go wrong; overestimating how bad it would be if it did go wrong; and underestimating personal resources and resources outside oneself which could help to make the situation manageable.
- 3 In order to prevent the predictions from coming true, people take precautions. In fact, these are unnecessary and indeed they make it impossible to discover if the predictions are correct or not.
- 4 In order to break the vicious circle and tackle anxious predictions, it is first necessary to learn to spot them as they occur, and observe their impact on emotion and on body state, and the unnecessary precautions they lead to.
- 5 The next step is to question the predictions, examining the evidence that supports and contradicts them, and searching for alternative, more realistic perspectives.
- 6 The final step is to gain direct experiential evidence of how accurate the predictions and the new alternatives are by setting up experiments, facing situations that are normally avoided, and taking the risk of dropping unnecessary precautions.

5

Combating self-criticism

Introduction

In low self-esteem, self-critical thinking follows the sense that negative beliefs about the self (the Bottom Line) have been confirmed by experience. It contributes to keeping low self-esteem going because it triggers feelings like guilt, shame and depression, and so perpetuates activation of the Bottom Line.

The impact of self-criticism

People with low self-esteem are hard on themselves. For them, self-criticism may be more or less a way of life. They call themselves names, tell themselves they should do better and put themselves down whenever things go wrong. They are on the lookout for every little weakness and mistake. These are not a part of normal frailty or natural human error – they are evidence of inadequacy or failure, a sign that one is simply not good enough. People with low self-esteem criticize themselves for all the things they should be doing and aren't – and for all the things they should not be doing and are. They may even criticize themselves for being so critical.

People with low self-esteem notice some difficulty, or something wrong about themselves, and on that basis make judgments about themselves as whole people ('stupid', 'incompetent', 'unattractive', 'rotten mother', etc.). These judgments completely ignore the other side of the picture, aspects of themselves which are not consistent with the judgment. The end result is a biased point of view, rather than a balanced perspective. And the bias expresses itself in self-critical thoughts.

Self-critical thoughts result in painful feelings (sadness, disappointment, anger, guilt), and keep low self-esteem going. Take Jim, for example, the man who accidentally knocked down and killed a woman who stepped off the pavement in front of him (page 46). At one point, after several months of being troubled by what happened, Jim had a few days of feeling considerably better. The accident seemed to be playing on his mind rather less, and he had been feeling more relaxed, more on top of things and like his normal self.

Then, one day, his daughter was very late home from school. Jim was terrified. He was certain something terrible had happened to her. In fact, he had forgotten that she was going to a friend's house. When she came in, he went ballistic. Afterwards, he felt thoroughly ashamed of himself. What a way to behave! 'This proves it,' he thought. 'I am really losing it. I'm a total mess.' He felt more and more upset. 'Pull yourself together,' he said to himself. 'This is pathetic. Get a grip.' The episode

confirmed his worst suspicions about himself: he *was* a neurotic wreck, there was no doubt about it. And there seemed little chance of change. Jim was just about ready to give up.

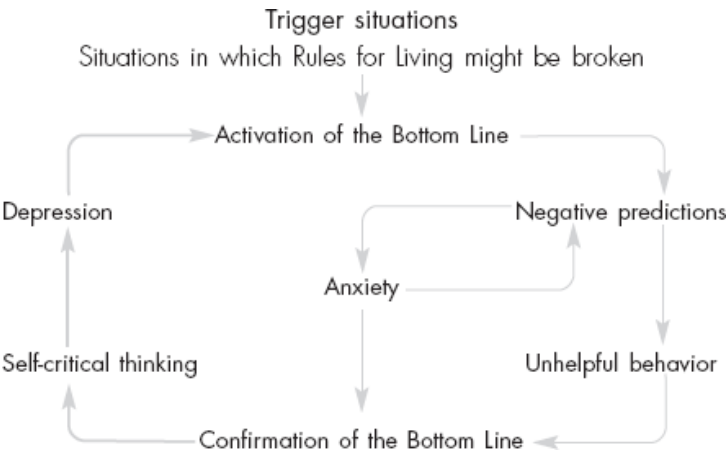
You can get some sense of the emotional impact of self-critical thoughts by carrying out the following experiment. Read the list of words printed below, carefully, allowing each to sink in. Imagine they apply to you, and notice their impact on your confidence, and on your mood:

Useless	Unattractive	Incompetent
Weak	Unlikeable	Ugly
Pathetic	Unwanted	Stupid
Worthless	Inferior	Inadequate

Self-critical thinking undermines any positive sense of self and pulls you down. Some of the words on the list may even be familiar to you, from your own self-critical thoughts. If so, underline them. What other words do you use to describe yourself when you are being self-critical? Make a note of them. These are words you will need to watch out for.

This chapter will move you towards a more balanced and accepting view of yourself by helping you to learn to notice when you are being self-critical, and to observe carefully the impact self-criticism has on your feelings and how you operate in day-to-day situations. This is the part of the vicious circle we shall be working on:

Figure 14 The vicious circle: The role of self-criticism in keeping low self-esteem going



You will learn how to question self-critical thoughts and search for alternatives, just as you learned to question your anxious predictions. You will also need to learn to become more aware of positive aspects of yourself, and to pay more attention to your strengths, assets, qualities and talents. You will find ideas on how to go about this in the next chapter.

Why self-criticism does more harm than good

In many cultures, self-criticism is viewed as a good and useful thing. This idea is captured in sayings like ‘spare the rod and spoil the child’, which suggests that the road to growth is through correction and punishment. People sometimes fear that thinking well of yourself will lead to boasting and big-headedness (we will return to this idea later, in the chapter on enhancing self-acceptance). So children are taught to behave better and work harder by having their faults emphasized, rather than by having their virtues and successes highlighted and praised. Parents and teachers may spend their time pointing out what children have done wrong, instead of helping them to build on what they have done right. This may breed a sense that self-criticism is the only thing that keeps one on the straight and narrow – stop, and you could sink into a swamp of smug self-indulgence and never achieve anything worthwhile, ever again.

So self-critical thinking is often learned early in life. It becomes a habit, a knee-jerk reaction, of which you may not even be fully aware. You may even see it as helpful and constructive – the royal road to self-improvement. This idea is worth exploring in some detail. You will discover that, in fact, self-criticism has a number of serious disadvantages.

Self-criticism paralyzes you and makes you feel bad

Imagine a person you know who is quite self-confident. Imagine following them around, pointing out every little mistake they make, telling them what they have done is all very well but could have been done better/faster/more effectively, calling them names and telling them to ignore or discount anything that went well, any successes or achievements. As the days and weeks went by, what impact would you expect this constant drip, drip, drip of criticism to have? How would they feel? How would it affect their confidence in their ability to cope and succeed in life? How would it influence their ability to make decisions and take initiatives? Would it make life easier for them or more difficult? Would you even consider doing this to a friend of yours? If not, why not?

If you have the habit of self-critical thinking, then this is probably what you are doing to yourself, perhaps without even being particularly aware of it. Self-critical thoughts are like a parrot on your shoulder, constantly squawking disapproval in your ear. Consider how this may be discouraging and demoralizing you, and paralyzing your efforts to change and grow.

Self-criticism is unfair

Being self-critical means that you react to even small mistakes, failures or errors of judgment as if they told the whole story about you. Your radar for faults and weaknesses is highly sensitive and, when you detect one, you use it as a cue to write yourself off. You tell yourself you are bad, pathetic or stupid *as a person*. Is this fair?

In fact, you are made up of millions of actions, feelings and thoughts – some good, some bad and some indifferent. When you condemn yourself as a person on the basis of an error or something you regret, you are drawing a general conclusion about yourself on the basis of biased evidence, taking only negative aspects of yourself into

account. Be realistic: give yourself credit for your assets and strengths as well as acknowledging that, like the rest of the human race, you have weaknesses and flaws.

Self-criticism blocks learning

Self-criticism undermines your confidence and makes you feel down, discouraged, demoralized and bad about yourself. Far from helping you to overcome problems, it prevents you from thinking clearly about yourself and your life and altering those aspects of yourself you genuinely want to change. Generally speaking, people learn more when their successes are rewarded, praised and encouraged than when they are criticized and punished for their failures. Self-criticism simply points you in the direction of what you did wrong and makes you feel bad – it does not give you any clues as to how to do better next time. If you only pay attention to what you do wrong, you lose the opportunity to learn from and repeat what you do right. Similarly, if you write yourself off every time you make an error, you lose the opportunity to learn from your mistakes and to work constructively on aspects of yourself that you wish to change.

Self-criticism ignores the realities

When things go wrong, in addition to criticizing yourself for what you did, you probably tell yourself you *should* have acted differently. Perhaps you are right in thinking that acting differently would have been in your best interests. With hindsight, it is often easy to see how one could have handled things better. But how did things appear to you *at the time*? In reality, the chances are that you had good reasons for acting as you did, even if in the end your course of action turned out to be mistaken, misguided or regrettable. Given all the circumstances (you were tired, you were not thinking clearly, you did not have all the information you needed to deal with the situation in the best possible way), you *should* have acted exactly as you did.

This does not mean letting yourself off the hook if you genuinely did do something worthy of regret, or ignoring genuine mistakes you have made. If you can see things more clearly in retrospect, use your new insight to learn from the experience. Then, if a similar situation arises again, you will have a different perspective on how to deal with it. But brooding on the past and using things you regret as a stick to beat your back with will only make you feel bad and paralyze you. It will not help you to think more clearly and do better next time.

Self-criticism kicks you when you are down

People sometimes demoralize themselves and reduce their confidence still further by criticizing themselves for being unconfident, unassertive, anxious or depressed. But these are common problems, and could probably affect most (or indeed, all) of us, given the right circumstances.

As we have seen, personal difficulties are often a natural reaction to stressful events, and, generally speaking, are an understandable product of early learning. They do not mean there is anything fundamentally wrong with you. In all probability, anyone who had had the experiences you have had would see themselves as you do, and with the same impact on daily living. With the help of this book, and other

resources if need be, you will be able to find ways to manage self-doubt and its consequences more successfully. What is certain is that criticizing yourself for having difficulties will not help you to resolve them.

Combating self-critical thoughts

Now that we have established how harmful self-critical thoughts can be, how can you set about dealing with them? The skills involved are very similar to those you used when you were learning how to question and test anxious predictions (Chapter 4). They are:

- Raising awareness of self-critical thoughts
- Questioning self-critical thoughts
- Experimenting with viewing yourself more positively

Each of these steps will now be explored in greater detail.

Raising awareness of self-critical thoughts

Becoming more conscious of your own self-critical thoughts is not always as easy as it sounds. Particularly if you have been lacking in self-esteem for a long time, self-criticism may have become a habit of which you are hardly aware – a routine part of how you think about yourself. So the first step is to learn to notice when you put yourself down, and to observe what impact it has on how you feel and how you go about the business of living.

When you are self-critical, your feelings will be affected. Changes in your emotional state are often your best cue that self-critical thinking is going on, especially if self-criticism is a well-rehearsed habit of which you are not fully aware. The emotions you experience when you are hard on yourself are probably different from the anxiety, apprehension, fear or panic that are triggered when you are predicting that things are about to go wrong. You are more likely to feel:

Guilty	Ashamed
Sad	Embarrassed
Disappointed in yourself	Angry with yourself
Frustrated	Depressed
Hopeless	Despairing

As you know, from working with anxious predictions, the first step towards changing old habits of thinking is to be able to spot them when they occur. Instead of being swept away by the feelings that go with self-criticism, you can learn to use them as a cue for action. Using the record sheet, ‘Spotting Self-Critical Thoughts’ on page 130 is a helpful way of doing this. Using the sheet will prompt you to notice what is running through your mind when you feel bad about yourself, and to understand

more clearly how these thoughts affect your life and how they keep the vicious circle of low self-esteem going. You may well find that the same thoughts (or very similar ones) occur again and again.

Over the course of a few days, you will become more sensitive to changes in your feelings, and to the self-critical thoughts that spark them off. Make sure that you bear in mind that these thoughts are a matter of opinion or an old habit, not a reflection of the person you really are. In this way, you can begin to distance yourself from them, even before you begin the process of questioning them systematically.

How to use ‘spotting self-critical thoughts’

The record sheet is designed to encourage self-awareness, to help you to tune into self-critical thoughts, as a first step to questioning them and searching for more helpful and realistic alternatives. You will see a blank example on page 130, and a completed example on page 131; additional blank copies are provided in the Appendix.

As with anxious predictions, a structured record sheet with headings may be more helpful to you than a daily narrative diary. It will help you to start thinking clearly about what is going on, instead of getting lost in telling the story or in your being upset. This is particularly important now that you are working on self-criticism, because self-critical thoughts are often quite close reflections of the Bottom Line and so may appear especially convincing to you.

The best way to become more aware of self-critical thoughts is to make a note of them as soon as they occur. You will see that the headings on the record sheet are very similar to the headings on the ‘Predictions and Precautions Record Sheet’ (page 92). You will need to write down:

Figure 1.5 SPOTTING SELF-CRITICAL THOUGHTS

Date/Time	Situation What were you doing when you began to feel bad about yourself?	Emotions and body sensations (e.g. sad, angry, guilty) Rate each 0-100 for intensity	Self-critical thoughts What exactly was going through your mind when you began to feel bad about yourself? (E.g. thoughts in words, images, meanings) Rate 0-100% for degree of belief	Self-defeating behavior What did you do as a consequence of your self-critical thoughts?

Figure 16 SPOTTING SELF-CRITICAL THOUGHTS – EXAMPLE: JIM

Date/Time	Situation What were you doing when you began to feel bad about yourself?	Emotions and body sensations (e.g. sad, angry, guilty) Rate each 0–100 for intensity	Self-critical thoughts What exactly was going through your mind when you began to feel bad about yourself? (E.g. thoughts in words, images, meanings) Rate 0–100% for degree of belief	Self-defeating behavior What did you do as a consequence of your self-critical thoughts?
5.3.2009	<i>Got in a rage with Kelly when she came home late. Had completely forgotten she was going to Jan's house</i>	<i>Guilty 80 Fed up with myself 100 Hopeless 95</i>	<i>This proves it – I'm really losing it 100% I'm a total mess 95% I should pull myself together 100% This is pathetic 100% What's the matter with me? I just don't think I'll ever get back to how I was 95%</i>	<i>Stomped out of the house and went to the pub. Came back late and shut myself in the basement alone to watch TV. Didn't talk to anyone.</i>

Date and time

When did you feel bad about yourself? Use this information to pick up patterns over time, as you did with your negative predictions.

The situation

What was happening at the moment you began to feel bad about yourself? Where were you? Who were you with? What were you doing? Briefly describe what was going on (e.g. 'asked a girl for a dance – she turned me down' or 'boss asked me to rewrite a report'). It may be that you were not doing anything in particular (e.g. washing up, watching television) and that what triggered self-critical thinking was not what was going on around you but rather something in your own general train of thought. In this case, write down the general topic you were focusing on (e.g. 'thinking about my ex-husband taking the children for the weekend' or 'remembering being bullied at school'). Your exact thoughts, word for word, belong in the 'Self-Critical Thoughts' column.

Emotions and body sensations

You may have felt only one main emotion (e.g. sadness). Or you may have experienced a mixture of emotions (e.g. not only sadness, but also guilt and anger). As with anxiety, you may also have experienced changes in your body state (e.g. a sinking feeling, a churning stomach or a weight on your shoulders). Write each emotion and body sensation down, and give it a rating between 0 and 100 according to how strong it was. Remember: a rating of 5 would mean just a very faint emotional reaction or physical change; a rating of 50 would mean a moderate level of distress; and a rating of 100 would mean the emotion or sensation was as strong as it could possibly be. You could score anywhere between 0 and 100.

Self-critical thoughts

What was running through your mind when you began to feel bad about yourself? Just as with anxiety, your thoughts may have been in words, like a conversation or commentary in your mind. You may have been calling yourself names, for example, or telling yourself you should have done better. Write your thoughts down, as far as possible, word for word. On the other hand, some of your thoughts may take the form of images in your mind's eye. Geoff, for example, the boy whose energy and curiosity got him into trouble as a child, saw his father's angry, disapproving face. Briefly describe the image, just as you saw it. If you can, note down the message the image is giving you (for Geoff, the message was that he had got it wrong yet again).

There may be times when you find yourself feeling upset but cannot identify any thoughts or images as such. If so, ask yourself what the *meaning* of the situation is. What does it tell you about yourself? What kind of person would find him- or herself in that situation, or would act that way? What implications does it have for what others think of you? What does it say about your future? This may give you a clue as to why the situation is upsetting you. A disagreement, for example, might mean that another person does not like you. A friend telling you about a new love affair might mean that, unlike other more worthy people, you will not find someone to love you. Reflect on the situation in which you began to feel bad about yourself, explore its meaning and, when you have found it, write it down. You will be able to question images and meanings and find alternatives to them, just as you can question and find alternatives to thoughts in words.

As with anxious predictions, give each self-critical thought, image or meaning a rating between 0 per cent and 100 per cent, according to how far you believed it

when it occurred. One hundred per cent would mean you believed it completely, with no shadow of doubt; 50 per cent would mean you were in two minds; 5 per cent would mean you only believed it slightly. Again, you could score anywhere between 0 per cent and 100 per cent.

Self-defeating behavior

What impact did your self-critical thoughts have on your behavior? Self-critical thoughts not only affect how people feel; they also affect how they act. They can lead you to behave in ways that are not in your best interests, and that will tend to keep your low self-esteem going.

In the last column of the diary sheet, make a note of anything you did, or did not do, as a result of the thoughts. For example, did you apologize for yourself? Or withdraw into your shell? Or avoid asking for something you needed? Did you allow yourself to be treated like a doormat or discounted? Did you avoid an opportunity that you might otherwise have taken?

Making the most of 'spotting self-critical thoughts'

Why bother to write it down?

Why not just make a mental note of what happens when you experience self-critical thoughts? Christine Padesky, a cognitive therapist from California, says: 'If you don't write it down, it didn't happen.' This highlights how having a record in black and white can help you. It means you have something concrete to think about and reflect on, and that incidents have less chance of being forgotten. You can notice repeating patterns, consider how thoughts affect your behavior in different situations and become aware of the exact words you use to yourself when you are being self-critical.

Equally, people often find that writing the thoughts down encourages distance from them. It takes them out of your head (so to speak), where it is difficult to question their truth because they seem so much a part of you, and puts them 'out there' on paper, where you can start to stand back from them, take a good look at them and gain a different perspective. This will help you to move towards the point where you can begin to say, 'Uh oh, there's another one of those,' and to see them as something you do, rather than a true reflection of yourself.

How long should I keep the record for? How many thoughts do I need to record?

Continue for as long as it takes to gain a clear understanding of your self-critical thinking and its impact on your emotional state and your behavior. You could start by noting one or two examples a day. Try to get a representative sample of self-critical thoughts. When you feel you have reached the point where noticing them and observing their impact has become fairly automatic, you are ready to move on to finding alternatives to your thoughts. This may take you just a few days. But if your habit of self-critical thinking is well dug in and mainly out of your awareness, it may take you longer.

When should I make the record?

As with anxious predictions, the ideal is to write down your self-critical thoughts as soon as they occur. This will mean keeping your diary sheet with you for a few days. The reason for this is that, although self-critical thoughts can have a very powerful effect when they actually occur, it may be hard afterwards to remember exactly what ran through your mind. This will make life difficult for you when you come to question the thoughts and look for alternatives to them.

But, of course, the ideal is not always possible. You may be in a meeting, or at a party, or changing the baby, or driving down a busy motorway. If you cannot write down what happened at the time, make sure that at least you make a mental note of what upset you, or jot down a reminder on any handy piece of paper (such as the back of an envelope, your diary or your shopping list). Then set aside time later to make a proper, detailed written record. Run through an ‘action replay’ in your mind – remember as vividly as you can where you were and what you were doing, the moment when you started to feel bad about yourself: what was running through your mind at that moment, and what you did in response to your thoughts.

Won't focusing on my thoughts just upset me?

Meeting your thoughts face to face may seem like a daunting prospect, especially if they closely reflect your Bottom Line and seem very convincing to you, and if the habit of self-criticism has been with you for a long time. You may be tempted to avoid looking at them too closely. Perhaps you are afraid that they will upset you. And what if they turn out to be true? Or perhaps part of you already knows that they are biased or exaggerated, and you feel you should be able to dismiss them rather than continuing to be distressed and restricted by them.

It is natural to want to avoid focusing on upsetting ideas, especially if one suspects they may be true. You may feel understandably reluctant to commit these damning judgments of yourself to paper. But if you want to combat your self-critical thoughts effectively, it is necessary first to look them straight in the face. You need to know the nature of the enemy. So beware of excuses (‘I’ll do it later’, ‘It doesn’t do to dwell on things’). If you act on them, you will deprive yourself of a chance to develop a more kindly perspective on yourself. And ignoring the thoughts will not make them go away.

Questioning self-critical thoughts

Developing awareness of your self-critical thoughts is the first step towards questioning them, instead of simply accepting them as a reflection of how things really are. You have already practised this skill when you were learning to check out your anxious predictions (remember the questions on page 105). The aim here is to stop taking your self-critical thoughts as if they were statements of the truth about yourself, and to begin to find alternative perspectives which will provide you with a more balanced view.

Figure 17 COMBATING SELF-CRITICAL THOUGHTS

Date/ Time	Situation	Emotions and body sensations Rate each 0-100	Self-critical thoughts Rate belief in each 0-100%	Alternative perspectives Use the key questions to find other perspectives on yourself. Rate belief in each 0-100%	Outcome 1 Now that you have found alternatives to your selfcritical thoughts, how do you feel (0-100)? 2 How far do you now believe the self-critical thoughts (0-100)? 3 What can you do (action plan, experiments)?

Figure 18 COMBATING SELF-CRITICAL THOUGHTS – EXAMPLE: JIM

Date/ Time	Situation	Emotions and body sensations Rate each 0-100	Self-critical thoughts Rate belief in each 0-100%	Alternative perspectives Use the key questions to find other perspectives on yourself: Rate belief in each 0-100%	Outcome 1 Now that you have found alternatives to your self-critical thoughts, how do you feel (0-100%)? 2 How far do you now believe the self-critical thoughts (0-100%)? 3 What can you do (action plan, experiments)?
8.3.2009	Had a row with Kelly again. She wanted to go out on a friend's motorbike	Guilty 80 Angry with myself 100 Hopeless 90	Here I go again, losing my temper about nothing. I'm a wreck 100% I've got to get a grip on myself, or I'll ruin every- thing 100% There's no end to this 90%	It's true that I was angrier than the situation warranted. But it's because I get frightened for her. Bikes are quite dangerous, and I'm afraid of losing her. So it wasn't really about nothing. 100% I do need to do something about all this, it's true. I have changed a lot. But then, I went through something really bad, so maybe it's not surprising I'm not my usual self. 90% Rows are not good for any of us. But in fact we usually get over it. She's a good girl, even if a bit of a cranky teenager at the moment. We have some good times together. 95% I don't know how to answer that. It's been going on a while. I don't like doing it, but maybe it's time to get help. 50%	1 Guilty 40 Angry with self 30 Hopeless 40 2 30% 20% 50% 3 Tell Kelly I'm sorry about shouting at her and explain why Talk to Viv (my wife) and tell her how I feel instead of shutting her out Get help?

On page 138 you will find a blank record sheet called 'Combating Self-Critical Thoughts'; additional blank copies are provided in the Appendix. A completed example is on page 139. You will see that the first four columns of this sheet are identical to 'Spotting Self-Critical Thoughts' (date/time; situation; emotions/body

state; self-critical thoughts). However, the new sheet does not stop there. It also asks you to record 'Alternative Perspectives', and to assess the impact these have on what you originally thought and felt. Finally, it asks you to decide on a plan of action to test out how helpful the alternative perspectives are.

In addition to continuing to collect the information you have been noting on 'Spotting Self-Critical Thoughts', you will need to write down:

Alternative perspectives

You will not have to snatch alternatives to your self-critical thoughts out of thin air. You can use the series of questions summarized on page 149 and discussed in detail later in the chapter, to help you generate alternatives and look at your thoughts from fresh angles. Rate each one according to how far you believe it, just as you rated the original self-critical thoughts (100 per cent if you believe it completely, 0 per cent if you do not believe it at all, and so on). You do not have to believe all your answers 100 per cent. They should, however, be sufficiently convincing to make at least some difference to how you feel.

Outcome

Go, back to your original emotions and body sensations. How strong are they now? Rate each one out of 100. Then go back to your original self-critical thoughts. Now that you have found alternatives to them, how far do you believe them? Give each one a new rating out of 100. If your answers have been effective, you should find that your belief in the self-critical thoughts, together with the painful emotions that go with them, have lessened to some extent.

Action plan

Here we return to the idea of experiments that was explored in Chapter 4. Work out what you need to do in order to test out your new perspectives in the real world, rather than leaving them on paper or in your mind. Experience is the best teacher: you will find your alternatives most convincing if you have discovered for yourself what impact they have, and how they change your feelings and the possibilities open to you.

Making the most of 'combating self-critical thoughts'

How long will it take to find good alternatives to my self-critical thoughts?

Questioning your self-critical thoughts and searching for alternative perspectives is probably not something you are in the habit of doing. At first, you may find the same old thoughts cropping up again and again. It may be difficult to free up your thinking and find alternatives that make much difference to how you see yourself or how you feel (though some people find it makes a noticeable difference right away). Don't rush things – give yourself plenty of opportunity to practise, learn from your mistakes and develop your skill.

The habit of self-criticism takes time to break. Changing your thinking is rather

like taking up a form of exercise you have never tried before. You are being asked to develop mental muscles you do not normally use. They will complain and feel awkward and uncomfortable. But, with regular practice, they will become strong, flexible and able to do what you require of them. And the exercise itself will feel good, let alone its results.

The objective of this stage is to reach the point where you automatically notice, answer and dismiss self-critical thoughts so that they no longer influence your feelings or how you act. Regular daily practice (one or two written examples a day) is the best way to achieve this. Later, you will be able to find answers to self-critical thoughts in your head without needing to write anything down. Eventually, you may find that most of the time you do not even need to answer thoughts in your head – they no longer occur very much. Even so, you may still find the record sheet helpful to deal with particularly tough thoughts, or at times when you are pressurized or unhappy for some reason. The record sheet is something you will always have in your ‘tool kit’ to deal with future difficulties and tough situations. But regular daily recordings need only go on until you achieve the objective of dealing with self-critical thoughts without a written prompt.

How can I expect to think differently when I'm feeling really upset?

If something happens that upsets you deeply, you will probably find it very difficult indeed to find alternatives to your self-critical thoughts. Instead of grasping that this is a common, natural difficulty, you may fall into the trap of seeing it as yet another reason to criticize yourself. The most helpful thing to do is simply to make a note of what happened to upset you, and your feelings and thoughts, but then to leave the search for alternatives until you are feeling calmer. You will be in a better position to see things clearly after you have weathered the storm.

How good does the record have to be?

Many people with low self-esteem are perfectionists who expect the highest possible standard in everything they do. ‘Good enough’ is not good enough. We shall be returning to perfectionist rules in Chapter 7. For the time being, however, it is important to bear in mind the purpose of the record: increasing self-awareness and increasing flexibility in your thinking. Approaching the record with a perfectionist stance will not help you to achieve this – it will create pressure to perform, and stifle creativity. Your record does not have to be a literary masterpiece, or a perfect piece of writing with every ‘i’ dotted and ‘t’ crossed. You do not have to find the one *right* answer, or the answer which you think you *should* put. The ‘right’ answer is the answer that works for you – the answer that makes sense to you, changes your feelings for the better, and opens up avenues for constructive action. No one answer, however sensible it may seem, will work for everyone. You need to find the one that works best for *you*.

What if my alternatives don't work?

Sometimes people find that the answers they come up with do not have the desired effect – they make little difference to how they feel, and they do not help them to operate differently. If this is the case for you, it may be that you are disqualifying the

answer in some way – telling yourself it is just a rationalization, perhaps, or that it might apply to other people, but not to you. If you have ‘yes, buts’ like this, write them down in the ‘Self-Critical Thoughts’ column and question them.

Do not expect your belief in the old thoughts and your painful feelings to shrink to zero right away, especially if they reflect beliefs about yourself which have been in place for many years. Self-critical thinking may be like a pair of old shoes – not very pleasant, but you are used to them and they are moulded to your shape. New perspectives, in contrast, are like new shoes – unfamiliar and stiff, and not at first a comfortable fit. You will need time and practice to strengthen the kinder view, and you will also need to experiment repeatedly with acting differently so that you learn on a gut level that self-acceptance works better for you than self-criticism.

What if I'm no good at this?

Don't allow yourself to get caught in the trap of self-criticism while you are recording your self-critical thoughts. Changing how you think about yourself is no easy task. It takes time and practice to build the skill. So beware of being hard on yourself when you find the going tough. If you had a friend who was trying to tackle something difficult, what would you consider would be more helpful to them? Criticism and punishment? Or encouragement and praise? You may catch yourself thinking ‘I must be really stupid to think this way’ or ‘I'm not doing enough of this’ or ‘I will never get the hang of this’. If you do spot thoughts like these – write them down and answer them.

Key questions to help you find alternatives to self-critical thoughts

People rarely manage to come up with alternatives to self-critical thoughts right away. The questions summarized on page 149 and detailed below are designed to help you explore fresh perspectives and recognize how your self-critical thoughts are subject to bias and distortion. You may find it helpful initially to use the list as a whole to help you get into the swing of questioning your self-critical thoughts. As you go along, notice which questions seem particularly helpful in tackling your own personal style of self-critical thinking (for example, you may find that you have a habit of taking the blame for things that are not your responsibility, or that considering what you would say to another person in your situation opens up new ideas for you). You could write down these especially helpful questions on a card small enough to carry in your wallet or purse, and use them to free up your thinking when self-critical thoughts strike. With practice, useful questions will become part of your mental furniture. At this point, you will no longer need a written prompt.

What is the evidence?

AM I CONFUSING A THOUGHT WITH A FACT?

Just because you believe something to be true, it does not follow that it is. I could believe that I was giraffe. But would that make me one? Your self-critical thoughts may be opinions based on unfortunate learning experiences you have had, not a reflection of your true self.

WHAT IS THE EVIDENCE IN FAVOUR OF WHAT I THINK ABOUT MYSELF?

What are you going on, when you judge yourself critically? What actual evidence do you have to support what you think of yourself? What facts or observations (rather than ideas or opinions) back up your self-critical thoughts?

WHAT IS THE EVIDENCE AGAINST WHAT I THINK ABOUT MYSELF?

Can you think of anything that suggests your poor opinion of yourself is not completely true? Or indeed contradicts it? For example, if you have criticized yourself for being stupid, can you think of anything about you, past and present, that does not fit the idea you are stupid?

Finding counter-evidence may not be easy, because you will tend to screen it out or discount it. This does mean it does not exist.

What alternative perspectives are there?

AM I ASSUMING THAT MY PERSPECTIVE ON MYSELF IS THE ONLY ONE POSSIBLE?

Any situation can be viewed from many different angles. How would you see this particular situation on a day when you were feeling more confident and on top of things? How do you think you will view it in ten years' time? What would you say if a friend of yours came to you with this problem? If your loss of confidence has been relatively recent, how would you have viewed the situation before the difficulty began? Remember to check out alternative perspectives against available evidence. An alternative with absolutely no basis in reality will not be helpful to you.

What is the effect of thinking the way I do about myself?

ARE THESE SELF-CRITICAL THOUGHTS HELPFUL TO ME, OR ARE THEY GETTING IN MY WAY?

In this specific situation, what do you want? What are your goals or objectives? Remember the earlier discussion on the pros and cons of self-critical thinking. Right now, do its disadvantages outweigh its advantages? Is it the best way to get what you want out of the situation, or would a more balanced, kindly, encouraging perspective be more helpful? Are your self-critical thoughts helping you to handle things constructively, or are they encouraging self-defeating behavior?

What are the biases in my thinking about myself?

AM I JUMPING TO CONCLUSIONS?

This means deciding how things are without proper evidence to support your point of view – for example, concluding that the fact someone didn't call you means that you have done something to offend them, when actually you have no idea what might be behind their behavior. People with low self-esteem typically jump to whatever conclusion reflects badly on themselves. Is this a habit of yours? If so, remember to

review the evidence, the facts. When you look at the bigger picture, you may discover your critical conclusion about yourself is incorrect.

Figure 19 Key questions to help you find alternatives to self-critical thoughts

What is the evidence?

- Am I confusing a thought with a fact?
- What is the evidence in favour of what I think about myself?
- What is the evidence against what I think about myself?

What alternative perspectives are there?

- Am I assuming my perspective is the only one possible?
- What evidence do I have to support alternative perspectives?

What is the effect of thinking the way I do about myself?

- Are these self-critical thoughts helpful to me, or are they getting in my way?
- What perspective might be more helpful to me?

What are the biases in my thinking about myself?

- Am I jumping to conclusions?
- Am I using a double standard?
- Am I thinking in all-or-nothing terms?
- Am I condemning myself as a total person on the basis of a single event?
- Am I concentrating on my weaknesses and forgetting my strengths?
- Am I blaming myself for things which are not really my fault?
- Am I expecting myself to be perfect?

What can I do?

- How can I put a new, kinder perspective into practice?
- Is there anything I need to do to change the situation? Even if not, what can I do to change my own thinking about it in future?
- How can I experiment with acting in a less self-defeating way?

AM I USING A DOUBLE STANDARD?

People with low self-esteem are often much harder on themselves than they would be on anyone else. Their standards for themselves are much higher, more rigid and more unattainable than the standards they expect other people to meet. Are you expecting more of yourself than you would of other people? Would you be so hard on them?

To find out if you are using a double standard, ask yourself what your reaction would be if someone you cared about came to you with a problem. Would you tell them that they were weak or stupid or pathetic, or that they should know better? Or would you be encouraging and sympathetic and try to help them to get the problem into perspective and look for constructive ways of dealing with it? People with low self-esteem sometimes fear that if they become kinder to themselves, they will cease to make anything of their lives. In fact, the reverse is probably true. Think of a child learning to walk and talk. If the child's parents shouted at it, and criticized it and called it names every time it fell over or said a word wrong, what impact would you expect that to have? Would you treat a child that way? If not, how come you are doing it to yourself?

How about trying a different policy? Take a step back from your usual critical and disapproving stance and be kind, sympathetic and encouraging to yourself, just as you would to another person. You may find that, if you treat yourself more kindly, you will feel better and be better able to think clearly and act constructively.

AM I THINKING IN ALL-OR-NOTHING TERMS?

All-or-nothing (or 'black-and-white') thinking oversimplifies things. Nearly

everything is relative (sometimes, not always or never; somewhat, not completely or not at all; some, not all or none). So, for example, people are not usually all good or all bad, but a mixture of the two. Events are not usually complete disasters or total bliss, but somewhere in the middle. Are you thinking about yourself in black-and-white terms? The words you use may be a clue here. Watch out for extreme words (always/never, everyone/no one, everything/nothing). They may reflect black-and-white thinking. In fact, things are probably less clear-cut than that. So look for the shades of grey.

AM I CONDEMNING MYSELF AS A TOTAL PERSON ON THE BASIS OF A SINGLE EVENT?

People with low self-esteem commonly make global judgments about themselves on the basis of one thing they said or did, one problem they have, one sole aspect of themselves. They take difficulties to mean that they have no worth or value at all as a person. Are you making this kind of blanket judgment of yourself? One person dislikes you, and it must mean there is something wrong with you? One mistake, and you are a failure? One, missed phone call, and you are irresponsible and selfish? Judging yourself as a total person on the basis of any one single thing you do does not make sense. Supposing you did one thing really well – would that make you totally wonderful as a person? Probably you would not even dream of thinking so. But when it comes to your weaknesses, failures and mistakes, you may be only too ready to write yourself off.

You need to look at the bigger picture. And remember especially that when you are feeling bad about yourself, or down, you will be homing in on anything that fits with your poor opinion of yourself, and screening out anything that does not fit. This skews your judgment even more. So hold back from making global judgments, unless you are sure that you are taking all the evidence into account.

AM I CONCENTRATING ON MY WEAKNESSES AND FORGETTING MY STRENGTHS?

Low self-esteem makes you focus on your weaknesses and ignore your assets. People with low self-esteem commonly overlook problems they have successfully handled in the past, forget resources that could help them to overcome current difficulties and screen out their strengths and qualities. Instead, they focus on failures and weaknesses. On a day-to-day basis, this may mean noting and remembering everything that goes wrong during the day, and forgetting or discounting things you have enjoyed or achieved. It may be difficult at bad times to think of a single good quality or talent.

It is important to try to keep a balanced view of yourself. Of course, there are things you are not very good at, things you have done that you regret, and things about yourself that you would prefer to change. This is true for everyone. But what about the other side of the equation? What are the things you *are* good at? What do other people appreciate about you? What do you like about yourself? How have you coped with difficulties and stresses in your life? What are your strengths qualities and resources? (We will return to this point in more detail in Chapter 6.)

Burka and Yuen (1983) have a clever way of describing this tendency to focus on the bad and ignore the good. They suggest that people who are down on themselves

have an extremely vigilant, powerful and effective ‘inner prosecutor’ who is alert for every flaw and weakness and ready to condemn at the drop of a hat. An equally strong ‘inner protector’ is needed, who will present the evidence for the defence. And, most importantly, an ‘inner judge’ must be developed who, like a real judge, will take *all* the evidence into account and come to a fair and balanced view, rather than condemning solely on the basis of evidence presented by the prosecution.

AM I BLAMING MYSELF FOR THINGS WHICH ARE NOT REALLY MY FAULT?

When things go wrong, do you consider all the possible reasons why this might be so, or do you tend immediately to assume that it must be due to some lack in yourself? If a friend stands you up, for example, do you automatically assume that you must have done something to annoy them, or that they do not want to know you any more?

There are all kinds of reasons why things do not work out. Sometimes, of course, it will indeed be a result of something you did. But often, other factors are involved. For example, your friend might have forgotten, or been exceptionally busy, or have misunderstood your arrangements. If you automatically assume responsibility when things go wrong, you will not be in the best position to discover the real reasons for what happened. If a friend of yours was in this situation, how would you explain what had happened? How many possible reasons can you think of? If you remain open-minded and ask yourself what other explanations there might be, you may discover that you are less to blame than you thought – in fact, what happened may have had absolutely nothing to do with you.

AM I EXPECTING MYSELF TO BE PERFECT?

As we have said, people with low self-esteem often set very high standards for themselves (we shall return to the question of standards in Chapter 7). For example, they may think they should be able to deal calmly and competently with everything life throws at them. Or they may believe that everything they do should be done to the highest standard, regardless of circumstances and personal cost. This is simply not realistic, and opens the floodgates to self-criticism and painful feelings of guilt, depression and inadequacy. It is just not possible to get everything 100 per cent right all the time. If you expect to do so, you are setting yourself up to fail.

Accepting that you cannot be perfect does not mean you have to give up even attempting to do things well. But it means you can set realistic targets for yourself, and give yourself credit when you reach them, even if they were less than perfect. This will encourage you to feel better about yourself, and so motivate you to keep going and try again. It also means you can learn from your difficulties and mistakes, rather than being upset and even paralyzed by them. Remember what Gary Emery, an American cognitive therapist, says: ‘If a thing is worth doing, it is worth doing badly.’

WHAT CAN I DO?

What can you do to put your new, kinder perspective into practice? How could you find out for yourself if it works better for you? Is there anything you can do to change

the situation that sparked the self-critical thoughts (for example, changing or leaving a job where you are not valued, or ending a relationship with a person who feeds into your negative view of yourself)? Or is there something about your own reactions you could change? Old habits die hard – what will you do if in future you find yourself thinking, feeling and acting in the same old way? How would you like to handle the situation differently, next time it occurs?

This will include spotting and dealing with self-critical thoughts. It may also involve experimenting with behaving in new ways that are less self-defeating (accepting compliments gracefully, not apologizing for yourself, taking opportunities, asserting your own needs, etc.). Write down your ideas on the sheet, and then take every opportunity to try them out, to develop and strengthen new perspectives on yourself.

CHAPTER SUMMARY

- 1 Self-critical thinking arises when you have the sense that experience has confirmed your Bottom Line. This chapter has focused on the steps that will help you to combat self-criticism and search for more realistic and helpful ways of thinking about yourself.
- 2 Self-critical thinking is a learned habit. It does not necessarily reflect the truth about yourself.
- 3 Self-criticism does more harm than good. Believing your self-critical thoughts makes you feel bad and encourages you to act in self-defeating ways.
- 4 You can learn to stand back from self-critical thoughts, and see them as something you do rather than a mirror image of your true self.
- 5 Self-critical thoughts, like anxious predictions, are open to question. You can learn to observe and record them and their impact on your feelings, body state and behavior, and to search for more balanced and kindly perspectives on yourself.
- 6 The final step is to experiment with treating yourself less harshly, valuing your strengths, qualities, assets and strengths as you would those of another person. This will be the focus of the next chapter.

6

Enhancing self-acceptance

Introduction

In Chapter 2, we discussed how low self-esteem is maintained by two complementary biases in thinking: a bias in perception, and a bias in interpretation. Correcting these biases by giving more weight to your good points and by countering self-critical thinking will make you feel better about yourself on a day-to-day basis. It is also a crucial part of establishing and strengthening a new, more positive and realistic Bottom Line.

Chapter 5 focused on the bias in interpretation: the way negative beliefs about yourself lure you into the trap of self-critical thinking. You learned how to spot and answer self-critical thoughts. In this chapter, we shall look at the other side of the coin: the bias in perception that makes you screen out positive aspects of yourself, and ignore or downgrade the good things in your life.

The chapter will begin with a reminder of how this mechanism operates, and then move on to suggest ways of changing the bias against yourself so that you stop giving prime time to aspects of yourself you are not happy about, and begin to enhance everyday awareness of your qualities: personal assets and resources, talents and strengths. You may find this change in bias is not as easy in practice as it sounds in theory. Just as the habit of self-criticism is often learned early in life, so a prohibition against thinking well of oneself may also be drummed in from an early age. Unless you are alert to it and prepared to counter its effects, this prohibition may prevent you from using the methods described in this chapter to enhance your self-esteem.

The taboo against positive thinking

I'm beautiful
I'm clever
I'm a brilliant cook
I have an excellent sense of humour
I have exceptional musical gifts
I'm adorable
I'm great

If you heard someone saying these things, what would your immediate reaction be? Would you be delighted to meet someone so gifted? Or would you feel uncomfortable and disapproving? Would you find yourself muttering 'Bighead', or 'Talk about blowing your own trumpet!', or 'Who on earth does s/he think s/he is?'?

Would you instantly take it for granted these things must be true? Or would you see such self-enhancing statements as boasting, getting above oneself? Would you feel this person was ripe for a fall, and it was about time they were cut down to size?

If you have low self-esteem, the chances are that you view the idea of making statements like these about yourself as uncomfortable, risky, abhorrent or plain wrongheaded. Thinking well of yourself, allowing yourself to acknowledge your good points, may seem to you identical to boasting. The very thought may make you squirm with embarrassment. You may also fear that, if you admit anything good about yourself, someone else will be sure to step in and say 'Oh, no, you aren't', or 'Do you think so? I hadn't noticed', or 'Really? I must say, that's not how I see you at all'. Thinking well of yourself in private may feel as extreme as hiring a sound system and standing in the town centre, shouting your virtues to the whole world. Naturally enough, these ideas and feelings stand in the way of enhancing self-esteem.

Like the habit of self-critical thinking, seeing self-acceptance as equivalent to smug self-congratulation is often learned early in life. Just as children are taught to focus on their mistakes and wrongdoings, so they may encounter disapproval and ridicule if they show any sign of appreciating their own successes. This can happen, for example, to intelligent, academically gifted children (especially, perhaps, girls), who do well at school and receive public praise from teachers. Schoolmates call them 'egghead'. At home, at least until recently, they may have been given the message that being clever is not a desirable quality in a woman. In adolescence, boys may feel uncomfortable with and avoid bright girls like these. As a consequence, the girls may learn to underperform or to hide and downgrade their successes, putting them down to luck rather than their own gifts. The problem is that these strategies can become a part of their own thinking. They stop valuing their talents and achievements, and come to believe that anything they do well is a fluke, not a reflection of inherent qualities and hard work. This process can take time and persistence to reverse.

Hans Christian Andersen wrote a story called 'The Snow Queen'. At the beginning of the story, the devil makes a mirror. No one who looks in the mirror sees a reflection of his or her true self, but rather a distorted image, twisted and ugly. If you have low self-esteem, you see yourself in this distorted way without the benefit of the devil's mirror. What jumps out at you is what you dislike about yourself – the weaknesses and faults that are an inevitable part of being human. Your qualities, assets, resources, strengths and skills are much harder to accept.

Like self-criticism, ignoring or undervaluing positive aspects of yourself is unfair. The idea that self-acceptance – noticing and taking pleasure in your strengths and qualities and treating yourself like someone who deserves the good things in life – will lead to complacency does not make sense. Self-acceptance (that is, a realistic appraisal of your strong points, just for yourself) is part of self-esteem, not self-inflation. Ignoring the positive contributes to keeping low self-esteem going, because it stops you from having a balanced view that takes account of the good things about you as well as genuine shortcomings and things you might prefer to change.

So try this experiment: use the methods discussed below to increase your focus on the positive and your acceptance of good things about yourself, and notice the impact this has on how you feel about yourself and how you go about your daily life. As you do so, you will also be chipping away at your Bottom Line and building the foundations for a new, more appreciative perspective on yourself.

Bringing positive qualities into focus

A helpful starting point in enhancing your appreciation of yourself is to make a list of your qualities, talents, skills and strengths. This task kills two birds with one stone. It will help you to build and strengthen a more positive view of yourself. It will also make you increasingly aware of how you go about screening out and discounting positives and so shut out experiences that might lead you to revise your opinion of yourself in a favourable direction. So while you are working on bringing positive qualities into focus, be alert to self-critical thoughts that disqualify your strong points and stand in the way of developing a more balanced, positive perspective on yourself. Your aim is to reach the point where you can calmly notice disclaimers ('Oh look, there's another one') and pass on without allowing them to get in your way, rather than taking them seriously and being knocked sideways by them. If you can do so, simply put them to one side and continue with your task. If they are too persistent or seem too convincing to let go in this way, write them down on a 'Combating Self-Critical Thoughts' sheet and answer them before moving on. Remember: they are a habit which will weaken, so long as you keep them in perspective and refuse to allow them to stop you from adopting a more positive perspective on yourself.

Some people find making a list of positive qualities quite easy. Their doubts about themselves may be relatively weak, or may only surface in particularly challenging situations. As well as a negative view of themselves, they may have more positive, helpful views which they can call on when it comes to identifying pluses. Other people, with very powerful and convincing Bottom Lines, can find listing positive qualities an almost impossible task. The habit of screening them out and discounting them may be so strong that it is difficult initially to accept any good points at all.

This may be very different from what your reaction would be if you were asked to make a list of your weaknesses and failings. You might well reach for the paper right away, and be scribbling busily for some time. If you have been discouraged from thinking well of yourself and told not to get above yourself, if your achievements have been ignored, and your needs regarded as unimportant, then it will be hard for you to begin to see yourself in a kindly, appreciative way. This does not mean that, with time and patience, you will not be able to see good things about yourself and value them. However, it may be that you will need some help, perhaps from a close friend or someone else you care about. It is worth investing your time in this task. Even if it takes a while to come up with a good list, making awareness of your positive qualities part of day-to-day living will have a considerable impact, over time, on how you feel about yourself.

In order to get started, select a time where you can be sure you will not be interrupted and settle down with a sheet of paper and a pen or pencil. Make sure you sit somewhere comfortable, where you can feel peaceful and relaxed. You could perhaps put on some music you enjoy. Now make a list of as many good things about yourself as you can think of. You may at once be able to list several. Or you may be hard put to think of even one or two. Give yourself plenty of time, and don't worry if the task is hard at first. You are trying something new, a fresh perspective on yourself, a shift of emphasis. Take your list as far as you can, and when you feel you have come up with as many items as possible for the time being, stop. Put the list somewhere easily accessible – it may even be helpful to carry it with you. Over the

next few days, even if you are not actually working on it, keep it at the back of your mind and add to it as things occur to you. Be pleased even if you can only find one or two things to begin with. You have made a good start in freeing up your thinking and taken the first crucial step towards acknowledging and accepting good things about yourself.

Helpful questions to get you going

If your self-esteem has been low for some time, you will very probably have difficulty in identifying your strong points and qualities. This does not mean that you do not have any – it means that you are out of the habit of noticing and giving weight to them. Here are some questions to help you get the ball rolling (you will find them summarized opposite).

What do you like about yourself, however small and fleeting?

Look out for anything about yourself that you have ever felt able to appreciate, even if only momentarily.

What positive qualities do you possess?

Include qualities that you feel you do not possess 100 per cent, or that you do not show all the time. No one is totally, utterly, completely kind/honest/punctual/thoughtful/competent/whatever all the time. Give yourself credit for having the quality at all, rather than discounting it because you have it to a less than perfect extent.

Figure 20 Questions to help you identify your good points

- What do you like about yourself, however small and fleeting?
- What positive qualities do you possess?
- What have you achieved in your life, however small?
- What challenges have you faced?
- What gifts or talents do you have, however modest?
- What skills have you acquired?
- What do other people like or value in you?
- What qualities and actions that you value in others do you share?
- What aspects of yourself would you appreciate if they were aspects of another person?
- What small positives are you discounting?
- What are the bad things you are not?
- How might another person who cared about you describe you?

What have you achieved in your life, however small?

You are not looking for anything earth-shattering here (winning the Olympics, being the first to cross the Antarctic on a donkey). Take account of small difficulties you have mastered and steps you have successfully achieved. My list, for example, would start with learning to ride a tricycle by pushing the pedals all the way round, rather than pumping them up and down.

What challenges have you faced in your life?

What anxieties and problems have you tried to conquer? What difficulties have you dealt with? What qualities in you do these efforts reflect? Facing challenges and anxieties takes courage and persistence, whether or not you resolve them successfully. Give yourself credit for this.

What gifts or talents do you have, however modest?

What do you do well? Take note: ‘*well*’, not ‘perfectly’! Again, remember to include the small things. You do not need to be Michelangelo or Beethoven. If you can boil a mean egg, or whistle a tune, or make farting noises by blowing on your baby’s tummy, then add it to the list.

What skills have you acquired?

What do you know how to do? Include work skills, domestic skills, people skills, academic skills, sporting skills and leisure skills. For example, do you know how to use a telephone, a computer, a microwave or a saw? Can you catch a ball? Can you drive a car or ride a bicycle? Do you know how to swim, how to sew or how to clean a bathroom? Are you good at listening to people, or appreciating their jokes? Can you read in a thoughtful way? Have you learned any languages? Think about all the different areas of your life and note down skills you have in all of them, however partial or basic.

What do other people like or value in you?

What do they thank you for, ask you to do, or compliment you on? What do they praise or appreciate? You may not have been paying much attention to this. Now is the time to start.

What qualities and actions that you value in other people do you share?

It may be easier for you to see other people’s strong points than your own. Which of the positive qualities you appreciate in others do you share? Beware of unfavourable comparisons, here. You do not have to be or do whatever it is as completely or well or to the same degree as the other person, but simply to acknowledge that you share the quality, even if only to a limited extent.

What aspects of yourself would you appreciate if they were aspects of another person?

Remember the double standard we discussed in the chapter on self-criticism. You may well be much readier to acknowledge and accept qualities or strengths that you can see in other people than the same qualities and strengths in yourself. Be fair. If there are aspects of yourself that you would appreciate if they were another person’s, write them on your list. Think also about things that you do that you would appreciate and value if another person did them. Write down anything that would count as a positive if it was done by someone else.

What small positives are you discounting?

You may feel that you should only include major positives on your list. Would you discount small negatives in the same way? If not, write the small positives down. Otherwise it will be impossible to achieve a balanced view.

What are the bad things you are not?

Sometimes people find it easier to think of positive qualities if they start by calling actively negative qualities to mind. The comparison highlights positives and strong points that might otherwise fade into the background and be taken for granted. So think of some bad qualities (e.g. irresponsible, cruel, dishonest or exploitative). Are you these things? If your answer is 'no', then by definition you must be something else. What are you (e.g. responsible, kind, honest or considerate)? Write down the mirror images of the bad qualities you identify. Again, do not discount them because they seem to you to be less than perfect.

How might another person who cared about you describe you?

Think about someone you know who cares about you, respects you and is on your side. What sort of person would they say you were? What words would they use to describe you? How would they see you as a friend, a parent, a colleague or a member of your community? People who know you and wish you well may have a kinder, more balanced perspective on you than you do on yourself.

In fact, if there is someone close to you, whom you respect and trust, it could be very helpful to you to ask them to make a list of the things they like and value in you. Make sure you approach someone who will complete this task in the spirit in which it is intended. Otherwise it may backfire on you. Do *not* ask anyone who has contributed to the development of your poor opinion of yourself, or whose behavior is currently feeding into it. Equally, do not ask anyone who believes strongly in the taboo against thinking well of yourself – the task may be too hard for them. Choose someone you have good reason to believe cares about you and wishes you well (e.g. a parent, a brother or sister, a partner, a child, a friend or a colleague with whom you have a close relationship). You may find their list a revelation, and it will strengthen your relationship. But again, watch out for thoughts which lead you to discount and devalue what you read (for example, that they are only doing it to be kind and can't possibly mean what they say). If you have thoughts like these, write them down and answer them on a 'Combating Self-Critical Thoughts' sheet.

Sarah, the artist whose parents had never been able to appreciate her talent, had some difficulty with her list, as you might imagine. Experience had taught her to place very little value on herself, and in particular to devalue what to other people appeared a striking gift. Initially, she could not think of anything to put on it except 'good-natured' and 'hard-working'. She found that, at first, trying to add other items roused all sorts of reservations (e.g. 'But other people are better at that than me' and 'But that isn't really important'). After a couple of tries, she used the questions on page 164 to free up her thinking. She still got stuck and abandoned her list for the time being two or three times, but eventually added 'thoughtful', 'practical', 'good colour sense', 'persistent', 'creative', 'kind', 'good taste', 'adventurous cook' and 'open to new ideas'. In addition, she screwed up her courage and asked an old and trusted friend if he would make a list of her good points too. He said it was about

time she gave her confidence a boost, and set to with a will. Sarah was moved and delighted by the affection that shone through his list. He echoed some of the items on her own list, and added 'makes me laugh', 'good listener', 'good drinking companion', 'has created a welcoming home', 'intelligent', 'sensitive' and 'warm'.

Making the abstract concrete

A list of positive qualities is the first step. However, a list on its own is not enough. You could put it in a drawer or filing cabinet – or, indeed, the waste-paper basket – and forget all about it. You will gain most benefit from it if you use it as a basis for raising your awareness of how your good points show themselves on a day-to-day basis. The idea is that, ultimately, awareness of the qualities, strengths and skills you have identified will be part of your mental furniture. You will notice and accept them quite routinely, without needing to make a special effort. Before you reach this point, however, you will need for a time to get into the habit of quite deliberately directing attention towards positive aspects of yourself.

Give yourself a few days to notice more items to add to your list and then, when you feel you have taken it as far as you can for the time being, once again find yourself a comfortable, relaxing spot and read the list to yourself. Don't skip through it at top speed. Pause and dwell on each quality you have recorded. Let it sink in. When you have read slowly and carefully through the list, go back to the top again. Now, as you consider each item, bring to mind a particular time when you showed that quality in how you behaved. Take time to make the memory as clear and vivid as you can. Get as close as you can to reliving the experience as if it were happening again. Close your eyes, and recall in detail when it was, where you were, who you were with, what exactly you did that showed the positive quality in action, and what the consequences were.

Sarah, for example, recalled a time when she had been home by herself and a friend had telephoned, apparently for a casual chat. Sarah picked up something in her friend's voice which prompted her to ask gently, *Are you OK?* Her friend burst into tears and confided that she had had an argument with her boyfriend and was feeling really depressed. She was pleased to have an opportunity to talk. Sarah was able to accept this as an example of her own sensitivity.

Notice what effect this exercise has on your mood and how you feel about yourself. If you can absorb yourself in it fully, you will find that the items on your list become much more vivid and meaningful to you. You should find your mood lifting, and a sense of self-acceptance and confidence creeping in.

If this does not happen, it could be that in some way you are disqualifying what you have written. Throughout the exercise, keep a watchful eye open for feelings of shame, embarrassment or disbelief. These feelings may be a cue that self-critical thoughts are going through your mind. Are you, for example, telling yourself that it's wrong to be so smug? Do you feel as if you are showing off? Are you thinking that what you did was trivial – anyone could have done it? Are you telling yourself it was only what would be expected of any decent human being? Or that you could have done it better? Or faster? Or more effectively? Or that you may be kind/supportive/competent or whatever some of the time, but not all of the time, and if it's not 100 per cent then it doesn't count? Are you devaluing qualities because other people have them too – they are too ordinary to be worth considering?

When disclaimers like these intrude, simply notice their presence (after all, old habits die hard, so they are hardly surprising) and then return your attention fully to focusing on your list of positive qualities. If the disclaimers are too strong to be ignored successfully, however, you can use the skills you have already learned for dealing with self-critical thoughts to tackle them.

Routine awareness of your good points: The ‘Positives Notebook’

Making a list of your positive qualities is the first step towards enhancing low self-esteem. Focusing on specific memories of those qualities in action begins the process of making them real to you, rather than something rather theoretical on a piece of paper which you can put away.

The next step is to make this awareness an everyday event, rather than something you cultivate for short periods from time to time, when you are not too busy. What you need to do here is to begin recording examples of your good points every day, as they occur, just as you have been recording examples of anxious predictions and self-critical thoughts. Your objective is to reach the point where you automatically notice good things that you do, without needing any written cue. You may reach this point in a few weeks, or it may take longer. Once you get there, there is no further need for written records.

One particularly helpful way of enhancing awareness of your good points is a ‘Positives Notebook’. Buy yourself a special notebook with an attractive cover, small enough to carry in a pocket, wallet or handbag. Using a special notebook, instead of any old piece of paper or a pad you have had hanging around the house for a long time, is a statement: it shows you are determined to notice and value aspects of yourself you have been ignoring, denying and taking for granted.

The aim is to use the notebook to record examples of your good points as they occur. The idea is to correct the bias against yourself by focusing on and highlighting your positive qualities, bringing them forward into centre stage instead of leaving them lurking in the wings. Use your list of qualities, skills, strengths and talents as a prompt to help you get started. Make sure you keep the notebook with you, so that you can write things down as soon as they happen. Otherwise, examples may be missed, forgotten or retrospectively discounted. Take one page for each day, and decide in advance how many examples of positive qualities you wish to record. Many people find that three is about right to start with. If this seems to be too many, however, then don’t be afraid to start with two, or even one. Wherever you start, as you get into the swing of it, you will be able to add more. When recording three incidents is easy, increase the number to four. When four is easy, go up to five, and so on. By then, noticing pluses should be pretty automatic.

For each entry in the notebook, write down what you did, and what quality it exemplifies. Here, as an example, are some of the items from Sarah’s first week of using a Positives Notebook:

- Spent several hours completing a large landscape painting (hard-working)
- Went out for the evening with Simon – haven’t laughed so much in ages (good drinking companion, funny)
- Bought flowers (creating a welcoming home)
- Tried cooking a Thai curry for the first time – tasted odd, but was edible (adventurous cook)

- Called Mother as it was her birthday (kind)
- Fixed shelving in workroom (practical)

At the end of each day, perhaps just before you go to bed, make time to relax and be comfortable and review what you have recorded. Look over what you have written, and recreate the memory of what you did in vivid detail. Let it sink in, so that it affects your feelings and your sense of yourself. You can also review the notebook weekly, to get the bigger picture, and to decide how many examples of good points to look out for next week. Additionally, the notebook will become a store of pleasurable and confidence-building memories that you can call on any time you are feeling stressed, low or bad about yourself.

Treating yourself to the good life

As well as failing to notice or value their good points, people with low self-esteem often miss out on the richness of everyday experience in two major ways: they do not put any effort into making life pleasurable and satisfying, and they do not give themselves credit for what they do. This section will describe ways of making your life more pleasurable and satisfying, and suggest how you can enhance self-esteem by giving yourself credit for your day-to-day successes and achievements, however small. These ideas will be particularly useful if your mood is low; in fact, they were originally devised as part of cognitive therapy for depression. One of the major side-effects of increasing the pleasure in your life and focusing on your good points is to lift mood. And a lift in mood makes it easier to combat self-criticism and break the vicious circle that keeps low self-esteem going.

Increasing pleasure and satisfaction: The ‘Daily Activity Diary’ (DAD)

The first step towards making the most of your everyday experiences is to get a clear picture of how you spend your time, how satisfying your pattern of daily activities is to you, and how good you are at acknowledging your achievements and successes. This self-observation is the jumping-off point for any changes you would like to introduce.

The ‘Daily Activity Diary’ (DAD) is one way of getting the information you need. You will find a blank example on pages 176–7, and an additional copy is provided in the Appendix. The example, partly completed, on pages 182–3 will give you a sense of how the diary might be used in practice. You will see that it looks something like a school timetable, with the days across the top and the time down the left-hand side. Each day is divided into hourly slots, in which you can record what you do and what you gain from what you do. This means noting how much you enjoy your activities and how far you give yourself credit for your achievements.

The diary can help you to identify changes you would like to make in how you spend your time, to focus your attention on the positive aspects of your experience (just as you have been focusing on positive aspects of yourself), and to tune into killjoy thoughts that get in the way of enjoyment and self-critical thoughts that lead you to discount and disqualify your successes. If you do not wish to use the DAD, you could instead use some other form of record (your actual diary, for example).

The benefit of an hour-by-hour diary is that it prompts you to notice what is going on in real detail. At the end of the day, you have an accurate record with lots of useful information, rather than a vague impression of how things have gone. So, however you choose to record your day, following an hour-by-hour format is likely to be most useful to you, at least until you have a clear sense of how you are spending your time.

Figure 21 DAILY ACTIVITY DIARY

	M	Tu	W	Th	F	Sat	Sun
6-7							
7-8							
8-9							
9-10							
10-11							
11-12							
12-1							
1-2							
2-3							
3-4							
4-5							

M O R N I N G A F T E R N O O N

E > E Z - Z O

	M	Tu	W	Th	F	Sat	Sun
5-6							
6-7							
7-8							
8-9							
9-10							
10-11							
11-12							

Review (What do you notice about your day? What worked for you? What did not work? What would you like to change?)

Mon:

Tues:

Wed:

Thurs:

Fri:

Sat:

Sun:

The first step: Self-observation

Over the course of a week or so, keep a detailed daily record of your activities, hour by hour. You will gather most useful information if the week you record is typical of your life at the moment. This is the information which will be most helpful when you come to consider changes you wish to make. If you record your activities over an exceptional week (e.g. you were on holiday, you were off sick, or your mother had come to stay), the information you gather will only really be directly relevant to

similar times in the future, not to your everyday life.

Each hour, write down:

What you did

Simply note the activity (or activities) you were engaged in. Anything you do counts as an activity, including sleeping and doing nothing in particular. Even ‘doing nothing’ is actually doing something. What does it mean exactly? Sitting, staring into space? Pottering around, doing minor domestic tasks? Sitting slumped on the couch, channel-surfing?

Ratings of pleasure (P) and mastery (M)

PLEASURE (P)

How much did you enjoy what you did? Give each activity a rating between 0 and 10. ‘P10’ would mean you enjoyed it very, very much. On the partially completed Diary on pages 182–3, for example, Sarah gave ‘P10’ to an evening at the theatre with friends. She felt she had thoroughly enjoyed herself. The play was excellent, funny and thought-provoking, and she had had a really good time with people she knew very well and felt completely relaxed with. ‘P5’ would mean moderate enjoyment. So, for example, Sarah gave ‘P5’ to a walk in the country by herself. She had enjoyed the warmth of the sunny day, but had miscalculated the distance, so that she was very tired by the time she got back to her car. ‘P0’ would mean you did not enjoy an activity at all. Sarah gave ‘P0’ to a meeting with her agent, who was hassling her to exhibit her recent paintings – even though normally she would have enjoyed his company as she liked and respected him.

You could, of course, use any number between 0 and 10 to show how much you enjoyed a particular activity. Like Sarah, you will probably find that your pleasure level varies, according to what you do. This variation will be a useful source of information to you. It shows you what works for you, and what does not work. It may give you clues about thoughts that get in the way of satisfaction and enjoyment (for example, Sarah was aware that she could not enjoy talking to her agent because she was preoccupied with apprehension about exposing her work to public view).

MASTERY (M)

How far was each activity an achievement, a mastery experience? ‘M10’ would mean a very considerable achievement. Sarah gave herself ‘M10’ for the phone call she made to her agent a couple of days after their conversation. This was because she called to agree that she would submit work to an exhibition, despite her anxieties. She gave herself a high ‘M’ rating as recognition that this was a difficult thing to do, and she had to push herself, but she did it. ‘M5’ would mean a moderate achievement. Sarah gave herself ‘M5’ the morning after her walk when she got up in time to complete a picture she was working on, despite feeling tired. Her first reaction was that getting up was nothing special, but she realized on reflection that, given how tired she felt, it was quite an achievement. ‘M0’ would mean no sort of achievement at all. Sarah gave herself ‘M0’ for an evening at home watching

television. This was pure self-indulgence, and she enjoyed it, but it did not involve any sort of achievement and so she felt happy to give it a 0 for 'M'.

Again, like Sarah, you could use any number between 0 and 10 to judge how much mastery you experienced carrying out a particular activity.

It is important to realize that 'mastery' does not only refer to major achievements like getting a promotion, hosting a party for 100 guests, or spring-cleaning the whole house from top to bottom. As you may have realized from Sarah's ratings, everyday activities can be real achievements, for which you deserve to give yourself credit. This is especially the case if you are feeling stressed, tired, unwell or depressed. When you are not in a good state emotionally, even relatively minor routine activities (taking the children to school, answering the telephone, making a snack, getting to work on time – even getting out of bed) can represent substantial achievements. Not recognizing this often leads people with low self-esteem to devalue what they do and, of course, this helps to keep low self-esteem going.

So when you rate 'M', make sure you take into account how you felt at the time. Ask yourself: 'How much of an achievement was this activity, *given how I felt at the time?*' If carrying out the activity represents a triumph over feeling bad, a real effort, a difficulty confronted, then you deserve to give yourself credit for it, even if it was routine, not done to your usual standard, or not completed.

Make sure that you rate all your activities for both P and M. Some activities (e.g. duties, obligations, tasks) are mainly M activities. Some are mainly P (relaxing and pleasurable things that we do just for ourselves). Many activities are a mixture of the two. For example, going to a party might warrant a good M rating if socializing makes you anxious, because it represents a triumph over your negative predictions. But once you arrived and began to relax and have a good time, the party could become enjoyable, too. In the long run, you are aiming for a balance of M and P. Giving both ratings to all your activities will help you to achieve this.

Figure 22 DAILY ACTIVITY DIARY – EXAMPLE: SARAH

	M	Tu	W	Th	F	Sat	Sun
6-7				Sleep	Sleep	Sleep	Sleep
7-8				Sleep	Sleep M0 P3	"	"
8-9				Sleep M0 P5	Got up; coffee; shower M3 P2	"	" M0 P5
9-10				Got up; breakfast; radio M1 P4	Out to buy art materials	M0 P5	Got up - tired: Break- fast; shower M5 P2
10-11				Worked M2 P4	" M3 P4	Got up; breakfast M2 P4	Worked M5 P2
11-12				" M2 P6	Coffee with M. M0 P6	Drove out to Henley M3 P4	" M4 P5
12-1				" M1 P6	Worked M6 P3	Lunch with Cousins M1 P6	" M4 P5
1-2			Met agent for I. wants me to exhibit M5 P0	Lunch in park M0 P6	" M6 P5	"	Lunch with J. M0 P6
2-3			" M4 P1	Cleaned up mess in apartment M7 P0	" M4 P7	"	"
3-4			Went round to see F. M0 P1	" M8 P0	Called agent & agreed to exhibit M10 P2	Walked along the river by myself M2 P5	Went to the Zoo w. J. M0 P8
4-5			" M0 P5	Sat & read M1 P4	Worked M4 P6	" M3 P5	"

M O R N I N G

A F T E R N O O N

Figure 22 DAILY ACTIVITY DIARY – EXAMPLE: SARAH

	M	Tu	W	Th	F	Sat	Sun
5-6			Worked M6 P3	Shopping M2 P3	" M4 P6	" M8 P3	Home M0 P2
6-7			" M4 P6	Met J. & F. for drinks & eat: M1 P6	Worked M3 P7	Drove home M3 P2	Worked M2 P4
7-8			Supper M1 P4	Theatre M0 P10	Supper M1 P4	Phoned Mum M4 P1	" M5 P2
8-9			P. came round, depressed M4 P2	"	TV M0 P6	Listened to music, thinking about work	" M3 P4
9-10			" M4 P4	"	" M0 P8	" M0 P6	" M2 P6
10-11			Read M0 P6	Pub again M0 P8	" M0 P7	Met P. for late drink M1 P1	Bed M0 P5
11-12			Bed M0 P4	Back to J's apartment M0 P8	Bed M0 P4	"	
12-1				"		Bed M0 P8!	

Review (What do you notice about your day? What worked for you? What did not work? What would you like to change?)

Mon:

Tues:

Wed:

Thurs:

Fri:

Sat:

Sun:

Didn't enjoy lunch at all. He was hassling me. As usual, couldn't believe anyone would really like my work.

Some good work, which I enjoyed. Great evening – worth planning more of this.

Hard to get started on work, but sticking with it paid off. Called agent and said yes – terrifying but I need to do it. Treated myself to relaxed, mindless evening at home.

Walk a good idea but too long. Should have paced myself.

Planned lunch with J a great success. Lot of fun watching street theatre in Covent Garden.

E > E Z - Z O

Review

At the end of each day, take a few minutes to look back over your diary. A brief daily review will encourage you to reflect on what you have done, rather than simply writing it down and leaving it. What do you notice about your day? What does the record tell you about how you are spending your time, and how much pleasure and satisfaction you get from what you do? What worked for you? What did not work? What were the high spots, both in terms of pleasure and of mastery? What were the low spots? What would you like more of? Less of? Different?

The DAD: Making the most of self-observation

How long should I carry on keeping the record?

The objective of the record is to give you a clear idea of how you are spending your time, and how pleasurable and satisfying your daily activities are to you. The record is also an opportunity to start noticing how negative thinking patterns (self-critical thoughts, anxious predictions) may prevent you from making the most of your experiences. So continue the record until you feel you have enough information for these objectives to be met. For many people, a week or two is enough. But if you feel you need more time to observe yourself, then there is no need to stop at that point.

When should I complete the record sheet?

It is important to record what you did, and your ratings, *at the time*, whenever possible. In the course of a busy day, things are easily forgotten. In addition, the biases against yourself that are present in low self-esteem are likely to give a clear memory of things that did not go well, and to screen out or minimize pleasures, successes and achievements. This will be all the more so if you are feeling generally low and bad about yourself. Noting your activities and ratings *at the time* will help to counter this bias. Immediate ratings also help you to tune into even small degrees of pleasure and mastery which may otherwise go unnoticed. Finally, if you put off recording what you do, you are more likely to forget altogether to do it, put it off until tomorrow, or perhaps give up altogether before you have collected the information you need.

What if I discover that I am not enjoying anything very much?

This could be because you are not making space in your day for enjoyable activities. You can use the DAD to check out if this is so. Perhaps you do not feel you deserve to enjoy yourself. Sarah, for example, became aware by keeping the record that, once she had committed herself to a particular piece of work, she did not feel entitled to make time for pleasurable activities until she had completed it and it had been approved.

Or perhaps you feel uncomfortable about putting yourself first, or taking time out just to relax (this is a common trap for parents, for example). If you suspect that this may be the case, look carefully at the pattern of your day. What proportion of time is given over to activities which are relaxing, pleasurable, fun and just for you? Remember the old saying: 'All work and no play, makes Jack a dull boy'. If your day is filled with tasks, obligations, duties and things you do with other people in mind, then increasing enjoyable activities may be one of your objectives at the next stage.

On the other hand, it could be that you are engaging in potentially pleasurable activities, but that 'killjoy thoughts' are preventing you from enjoying them fully. You can also use the record to begin to become aware of these thoughts. Look for examples of activities which look intuitively as though they should be enjoyable, but in fact were not. What was going on while you were engaging in them? Were you fully absorbed in what you were doing? Or were you actually preoccupied with other things (like Sarah with her agent)? Or making comparisons with other people, who seem to be enjoying themselves more than you? Or comparisons with how things

used to be at some time in the past? Or with how you think things *should* be?

If, when you engage in potentially pleasurable activities, your mind is actually elsewhere, then you will not enjoy them. So watch out for these 'killjoy thoughts' and practise putting them to one side and focusing on what you are doing. If they are too strong to put to one side, then write them down and look for answers to them. This is the beauty of the skills you have learned for dealing with negative thoughts. You can apply them to anxious thoughts, self-critical thoughts, killjoy thoughts – and, indeed, any other thoughts that upset you.

There is one other possibility, if you find that you are not really enjoying anything at all as you used to. This is one of the classic signs of depression. So if your capacity to experience pleasure seems impaired right across the board, check back to the signs of depression described in Chapter 1 (page 13). If this picture fits you, you may need to seek treatment for depression in its own right. A good starting point might be to read Paul Gilbert's book in this series, *Overcoming Depression*. If that does not help, then go to your doctor.

What if I'm not achieving anything?

If this appears to be the case, use your record and your observation of your thoughts about what you do to find out more about what is going on. It could be that low self-esteem (especially anxious predictions and self-critical thoughts) is leading you to restrict your field of activities. Do you miss opportunities, for example, out of anxiety that you will not be able to cope with them? Do you avoid social contacts, lest you make a fool of yourself, or people reject you? Do you shun challenges, convinced that you will not be able to meet them? If this is the case, then continuing to work on your anxious and self-critical thoughts can be used as a first step to extending your range or experimenting with a wider range of activities, which will allow you to gain a more positive view of your capabilities and enhance your sense of achievement.

Alternatively, it could be that you already engage in a wide range of activities, including some that are quite difficult or challenging or need a lot of effort, but that you allow self-critical thinking to undermine your sense of achievement. As we have discovered, self-critical thinking undermines motivation and gives a false impression that you are achieving nothing. It may well be based on very high standards you have for yourself (your Rules for Living). Perhaps these prevent you from acknowledging and accepting small successes and achievements because they are not special enough, or should have been done better or faster or more completely.

The kind of thoughts that get in the way of giving weight to positive qualities can also prevent you from giving yourself credit for day-to-day achievements. Watch what runs through your mind when you complete a task. Do your thoughts make you feel good and motivate you to do more? Or do they demoralize and discourage you and leave you feeling you did not do very well and there's little point in continuing? If so, you need to write them down and tackle them, using the skills you have already acquired.

Sarah certainly found this to be the case when she first started recording what she did on the DAD. Here are some examples of her self-critical thoughts and how she answered them:

Figure 23 Sarah's self-critical thoughts

Self-critical thoughts	Alternatives
I'm never going to finish this	Take things one thing at a time. You're doing fine. Focus on what you have accomplished, not on what you've still got to do. And give yourself credit for what you have done, even if you don't achieve everything.
This is not worth doing	You always think that, until someone tells you what you've done is OK. Never mind what other people think – those colours are great. And this painting is a real voyage of discovery for you – whether other people think it was worthwhile or not.
So I got out of bed. So what?	So good for me. I was really exhausted. I could have slobbered around all day, and I didn't.
I shouldn't be taking the evening off. I haven't done enough	Doing things I enjoy helps me feel better about myself and then I relax and think more creatively. If I drive myself non-stop and rush at things like a chicken with its head cut off, I'll grind to a halt in the end. I know from experience that I get more done when I give myself time off than when I plough on regardless.

This links back to what was said in Chapter 5 about experimenting with acting more kindly and tolerantly towards yourself, instead of putting yourself down and encouraging self-defeating behavior. You can see how the thoughts that prevent Sarah from making the most of her experiences are offshoots of her Bottom Line ('I am unimportant, inferior') and of one of her Rules for Living ('Nothing I do is worthwhile unless it is recognized by others'). You can see Sarah learning to be more encouraging and appreciative towards herself, to notice and build on her successes, and to treat herself like someone who deserves praise, relaxation and pleasure. Doing these things will chip away at her Bottom Line and help her to act against her rules, before she is ready to begin to tackle them head on.

The second step: Introducing changes

Now that you can see how you are spending your time, the next step is to use your observations as a basis for introducing changes that will increase your enjoyment and your sense of mastery and achievement. Your daily review of your diary should already have given you a good sense of some of the changes you would like to make. You can now move on to use the observations you have made and the conclusions you have reached to begin planning ahead, so as to ensure a balance between Mastery activities (duties, challenges, obligations, tasks) and Pleasure activities (relaxation, enjoyment).

Initially, it may be worthwhile to do this quite systematically, using the DAD. This may be particularly important if, at the moment, you are feeling rather low and finding it difficult to motivate yourself. It may also be helpful if self-observation has shown you (for example) that you have strong perfectionist standards that make it difficult for you to give yourself credit for what you do, or that you have problems in putting yourself first or in getting down to things you need to do but have been putting off. Alternatively, simply making a list every day of two or three particular things you wish to do (tasks you have been avoiding, perhaps, or things you will enjoy) may be enough to change the balance of your activities in a way that works for you.

Either way, once you get the hang of planning ahead, you may well find that you are automatically looking after yourself by balancing out Mastery and Pleasure without needing to write anything down. You may nonetheless continue to find a full written plan helpful at times in the future, for example when you are particularly busy or under pressure. Then it becomes simply an aspect of effective time management, and a reminder that being busy need not necessarily exclude pleasure and relaxation.

If you have decided to experiment systematically with planning ahead, you will need to write down:

Your plan for the day

You may prefer to do this first thing in the morning, or in the evening. Choose whichever time is likely to be most helpful to you. For example, if your morning is usually madly busy getting children off to school and yourself off to work, you could do without the extra task. Use the evening (perhaps when you are relaxing just before going to bed) instead. If, on the other hand, you are normally too tired in the evening to think straight, but usually wake feeling refreshed, then use the morning. You can write your plan in pencil on the DAD itself, if you wish, or on the back of the sheet, or on a completely separate piece of paper.

Each day, aim for a balance between pleasure and mastery. If you fill your time with duties and chores, and allow no time for enjoyment or relaxation, you may end up tired and resentful. On the other hand, if you completely ignore things you have to do, you may find your enjoyment soured by a sense that nothing has been achieved, and the list of tasks you are putting off will hang about at the back of your mind, making it difficult to make the most of your pleasures.

Record what you actually do

Use your plan as a guide for the day, and write down what you actually do on the DAD. If you wrote your plan down in pencil, write what you actually did in a different colour so that it is easy to see which is which. Rate each activity out of 10 for Pleasure and Mastery, just as you did at the self-observation stage.

Review your day

At the end of each day, take a few minutes to sit down comfortably, relax, and review what you have done. Thoughtfully examine how you spent your time. How far did you stick to your plan? If you did not, why was that? Did you get sidetracked? Did something come up that you had not predicted? Had you planned too much to start with? How much enjoyment and satisfaction did you get from what you did? How good was your balance between P and M? What would you like more of? Less of? Different?

This information will help you to get an increasingly clear idea of changes you might like to make in the pattern of your day.

Making the most of planning ahead

What if my plan is a success?

Success means devising a realistic plan, with a good balance of pleasurable activities and achievements, accomplishing what you set out to do, and getting the enjoyment and sense of mastery you wanted. If your plan works for you in this way, you have something really positive to build on. You have clearly found a pattern to the day which works well for you, and which you will want to repeat.

However, even if generally speaking your plan is a success, you may still find it helpful to carry out some fine-tuning. For example, you might want to add in regular exercise, or quality time with your family. You might decide to contact someone you have lost touch with, or to tackle a particular task you have been putting off. You might make the time finally to try something you have always wanted to do, or take the first steps towards new challenges or lifestyle changes you have been considering.

What if my plan is a failure?

Plans can fail to work out for many reasons. Although you may feel disappointed that things did not work out as you had hoped, your plan's 'failure' is, in fact, likely to be very useful to you. It may well tell you things you need to know about how your pattern of activity is not working well for you.

Perhaps you failed to stick to your plan for some reason that you are unhappy about. Supposing, for example, you planned to spend an evening at the cinema with a friend, but then a colleague persuaded you to work late instead. Or supposing you planned to spend a whole morning sorting out your financial affairs, but somehow you never got round to it. Here is potentially valuable information about what might be preventing you from making the most of your experiences. What exactly was the problem? Did you overestimate what you could do in a particular chunk of time? Did you plan too much and exhaust yourself? Did you spend the day doing things you felt you *ought* to do, rather than things that you would enjoy? Did you forget to include

breaks: time for yourself or relaxation? Conversely, did you fritter away your time on nothing in particular and end up feeling you had had a wasted day? Did you end up doing what everyone else wanted, rather than what would have been good for you? Are these patterns familiar to you? Are there other situations in which you operate in the same way? Could what went wrong with your plan be a reflection of a more general rule or strategy of yours?

If you can understand the nature of the problem, you will be in a position to begin tackling it, by making practical changes and by identifying and questioning the self-defeating thoughts (like Sarah's on page 189) that are keeping you stuck. You may well find that what kept you from fulfilling your plan also gets in your way in other areas of your life.

What if I can't think of anything pleasurable to do?

Particularly if low self-esteem has prevented you from looking after yourself and taking pleasure in life, you may well find it hard to think of things to do that you might enjoy. It may be helpful to treat this difficulty as a special project: how many ways to enjoy yourself can you think of, however unlikely?

You might like to start by noticing what other people do for pleasure. What about your friends, and other people you know? What about what you see in the media? What about all the activities on the notice-board in your local library and college of further education? What do you notice people enjoying when you are out and about? Make a list.

Then think about yourself. Even if you are not doing much for pleasure right now, have there been times in the past when you had things you enjoyed? What were they? Is there anything you have always fancied doing, but never got around to? What are all the possible things you could do, even if you have never tried them? Add these things to your list.

Think of all the different kinds of pleasures that might work for you under different circumstances. What could you do alone (e.g. reading, watching TV or going for walks)? What could you do with other people (e.g. going to the pub, joining an evening class or going to an art gallery)? What can you do that takes time (e.g. holidays, day trips or going to stay with people)? What can you do that can be easily fitted into the corners of your day (e.g. having a cup of special tea or a glass of special beer, soaking in a hot scented bath or pausing to glance out of the window)? What can you do that costs money (e.g. buying some flowers, going to the cinema or having a meal out)? What can you do that is free (e.g. looking at a sunset, window-shopping or looking through old photographs)? What physical pleasures can you think of (e.g. going swimming, flying a kite or having a massage)? What pleasures can you think of that use your mind (e.g. listening to a debate, doing a jigsaw or a crossword)? What can you do out of doors (e.g. taking care of your garden, going to the beach or going for a drive)? And what can you do at home (e.g. choosing clothes from a catalogue, listening to music or playing computer games)? Add all these things to your list.

Once you have a list of potential pleasures, plan them into your day. You may still have doubts about whether they will work for you. There is only one way to find out! And remember to watch out for killjoy thoughts. Put them to one side, if you can, and write them down and answer them if they persist in getting in your way.

When you give yourself pleasures like these, you are treating yourself like someone you love and care about. This is exactly the approach you need to take to enhance your self-esteem. So look after yourself. You deserve it.

How can I deal with the fact that my day is genuinely full of obligations?

If your day is genuinely busy with things you have to do, it can be difficult to make time for pleasure and relaxation. How can you possibly fit in even one more thing? People with jobs and families, people caring alone for young children or elderly parents and people with heavy commitments in public life – in fact, all of us, at one time or another – find it hard to achieve a balance between obligations and pleasures. It is very important to realize, however, that failing to make time just for yourself can backfire on you. You may find that you become increasingly tired and stressed so that, in the end, you are no longer able to do all the things you have to do as well as you would like to. Your health may even be affected. So finding time for relaxation is crucially important to your well-being and that of people around you.

If you adopt the stance that relaxation and pleasure are your right, and that you deserve to care for yourself as you might care for another person, you will be better able to make room for small pleasures, even on very busy days. Think of them as rewards for all your efforts, to which you are fully entitled. Make five minutes for a cup of coffee and a short walk round your building. Take ten minutes for a shower with special soap. Choose something to eat for supper that you really like. Buy a small bunch of flowers that does not cost much. Listen to a favourite program on the radio while you do the ironing or fix the car. Take advantage of your baby falling asleep to sit and read a magazine instead of feeling obliged to catch up with the housework. Be ingenious and creative, and don't allow yourself to be ground down by a relentless round of tasks and obligations. In the long run, you will not do yourself or anyone else any good.

How can I tackle all the things I have been putting off?

If you have been putting things off for a while, the prospect of facing them may seem rather daunting. However, tackling practical problems enhances a person's feeling of competency and so contributes to self-esteem. Conversely, avoiding problems and tasks is likely further to undermine your sense that you are in charge of your life, and contribute to feeling bad about yourself.

You can begin to get a grip on problems you have been putting off by following these steps:

- 1 Make a list of the tasks you have been putting off and problems you have been avoiding, in whatever order they occur to you.
- 2 If you can, number the items on the list in order of importance. Which needs to be done first? And then what? And then what? If you cannot decide, or it genuinely does not matter, simply number them in alphabetical order, or in whatever order they first occurred to you.
- 3 Take the first task or problem on the list. Break it down into small, manageable steps. Rehearse the steps in your mind. As you do so, write down any practical problems you might encounter at each step, and work out what

to do about them. This may involve asking for help or advice, or getting more information.

- 4 As you rehearse what you plan to do, watch out for thoughts that make it difficult for you to problem-solve or tackle the task. You may find anxious predictions coming up (for example, you won't be able to find a solution, you'll never get everything done). Or you may find yourself being self-critical (e.g. you should have dealt with this weeks ago, you are a lazy slob). If this happens, write your thoughts down and look for more helpful alternatives to them, as you have already learned to do.
- 5 Once you have a step-by-step plan you feel reasonably confident of, tackle the task or problem one step at a time and dealing with any practical difficulties and anxious or self-critical thoughts as they occur – just as you did in your rehearsal.
- 6 Write down the end result on your Daily Activity Diary, and give yourself ratings for P and M. Remember that even a small task completed, or a minor problem solved, deserves a pat on the back, if you have been putting it off! Acknowledge what you have achieved, rather than harping on about everything you have still to do.
- 7 Take the next task on the list, and tackle it in the same way.

CHAPTER SUMMARY

- 1 Enhancing self-esteem involves focusing attention on your strong points and on the good things in your life, as well as tackling anxious predictions and self-critical thoughts.
- 2 Ignoring your strong points and downgrading achievements and pleasures are part of the bias against yourself that keeps low self-esteem going.
- 3 You can counter the bias by listing your qualities, skills, talents and strengths and noting examples of these in your daily life (the Positives Notebook).
- 4 You can also use a Daily Activity Diary to observe how you are spending your time and how much pleasure and satisfaction you get from what you do.
- 5 These observations are a basis for starting to treat yourself to the good life, maximizing day-to-day pleasures and achievements.

Changing the rules

Introduction

Anxious predictions and self-critical thoughts do not come out of the blue. As you learned in Chapter 3, they are usually the end result of underlying Rules for Living, often formed early in life and designed to help a person get by in the world, given the apparent truth of the Bottom Line. The purpose of rules is to make life more manageable. But in fact, in the long run, they stand in the way of getting what you want out of life, and prevent you from accepting yourself as you are.

Rules for Living are reflected on a day-to-day basis in strategies or policies, ways of acting which ensure that their terms are met. When you have low self-esteem, your personal rules determine the standards you expect of yourself, what you should do in order to be loved and accepted, and how you should behave in order to feel that you are a good and worthwhile person. Personal rules keep you on the straight and narrow. They may also detail the consequences if you fail to meet their terms.

Briony's rule about relationships would be an example of this: 'If I allow anyone close to me, they will hurt and exploit me.' Since the consequences of breaking the rules are generally painful, you may have become exquisitely sensitive to situations where their terms might not be met. These are the situations which are likely to activate your Bottom Line, leading to the vicious circle of anxious predictions and self-critical thinking described in Chapter 3.

By now, you have discovered how helpful it is to check out anxious predictions and to combat self-critical thoughts. However, stopping at the level of day-to-day thoughts, feelings and actions and leaving your Rules for Living and your Bottom Line untouched might be equivalent to dealing with weeds in your garden by chopping their heads off rather than digging up their roots. This chapter will tell you how to go about identifying your own personal rules. It will help you to see how they contribute to low self-esteem, and suggest how to go about changing them and formulating new rules, which will allow you more freedom of movement and encourage you to accept yourself, just as you are.

As you work through the chapter, it is worth summarizing in writing what you discover about your rules, your line of argument when you question them, your new rule and your action plan for putting it into practice. You will find some suggested headings on page 203, and an example of a summary on page 208. The headings echo the questions you will find later on in the chapter, and will help you to organize your thoughts in a form that you can come back to and use to ensure that new understanding has a practical impact on your life. This is important because unhelpful rules for living can be difficult to change. A line of argument which seems

crystal clear to you when you work through the chapter may become hazy and difficult to grasp next time you are in a problem situation and have real need of it. A written summary will help you to keep your new perspective in view and make it easier for you to act on it, even when the going gets tough.

Where do rules for living come from?

Rules can be helpful. They help us to make sense of what happens to us, to recognize repeating patterns, and to respond to new experiences without bewilderment. They can even help us to survive (e.g. 'I must always look both ways before crossing the road'). Rules are part of how society is organized. National constitutions, political ideologies, legal frameworks, religious beliefs, professional ethics and school codes of behavior – all these are rules.

Figure 24 Changing the rules: Headings for a written summary

• My old rule is:	State the rule in your own words
• This rule has had the following impact on my life:	Summarize the ways in which your old rule has affected you
• I know that the rule is in operation, because:	Note the clues that tell you your old rule is active (thoughts, feelings, patterns of behavior)
• It is understandable that I have this rule, because:	Summarize the experiences which led to the development of the rule and have reinforced it

<ul style="list-style-type: none"> • However, the rule is unreasonable, because: 	Summarize the ways in which your rule does not fit the way the world works
<ul style="list-style-type: none"> • The payoffs of obeying the rule are: 	Summarize the advantages of obeying the rule and the risks of letting it go. Check to see if these are more apparent than real
<ul style="list-style-type: none"> • But the disadvantages are: 	Summarize the harmful side effects of obeying the rule
<ul style="list-style-type: none"> • A more realistic and helpful rule would be: 	Write out your new rule, in your own words
<ul style="list-style-type: none"> • In order to test-drive the new rule, I need to: 	Write down how you plan to strengthen your new rule and put it into practice in everyday life

Parents pass on rules to their children, so that they will be able to deal with life independently (e.g. 'Make sure you eat a balanced diet'). Children also absorb rules from their families and parents purely by observation. They notice connections (e.g. 'If I don't tidy my room, Mum will do it for me') and these can become a basis for more general rules (e.g. 'If things go wrong, someone will be there to pick up the pieces'). They tune into expectations that may never be put into words. They notice what is praised and what is criticized, what brings a smile to a parent's face and what causes a frown. All these experiences can become a basis for personal rules with a lasting impact on how people live their lives.

Helpful rules tend to be tried and tested, based on a solid foundation of experience. They are flexible, and allow the person to adapt to changes in circumstances and to respond differently to different people. So, for example, a person from one culture who travels to another will be able to adapt successfully to local social conventions, so long as their rules for how to relate to people are flexible and open. But if their social rules are rigid, and especially if they are viewed as the *right* way to behave, the person may run into difficulties.

Some rules, instead of helping us to make sense of the world and negotiate its demands successfully, trap us in unhelpful patterns and prevent us from achieving our life goals. They are designed to maintain self-esteem – in fact, they undermine it, because they place demands on us that are impossible to meet. They make no concessions to circumstances or individual needs (e.g. 'You must always give 110 per cent, no matter what the cost'). These extreme and unbending rules create problems. They become a strait-jacket, restricting freedom of movement and preventing change.

Rules that make you vulnerable to low self-esteem may operate in many areas of life. They may determine the performance you expect of yourself in a range of

different situations. Perfectionist rules like Jesse’s, for example, may not only require high-quality performance in the work environment, but might also require perfection in your physical appearance, in where you live or in how you carry out the most mundane of everyday activities.

Rules can restrict your freedom to be your true self with other people. Like Kate, you may have the sense that approval, liking, love and intimacy are all dependent on your acting (or being) a certain way. Rules may even influence how you react to your own feelings and thoughts. Like Jim, you may base your good opinion of yourself on being fully in control of your emotions, your thoughts and what life throws at you. Unhelpful rules like these imprison you. They build a wall of expectations, standards and demands around you. Here is your chance to break out.

The relationship between Rules for Living and the Bottom Line

Unhelpful rules are like escape clauses, ways around the apparent truth of the Bottom Line. For example, at heart, you might believe yourself to be incompetent. But *so long as* you work very hard all the time and set yourself high standards, you can override your incompetence and feel OK about yourself. Or you might believe yourself to be unattractive. But *so long as* you are a fount of funny stories, the life and soul of the party, maybe no one will notice and so again you can feel OK about yourself.

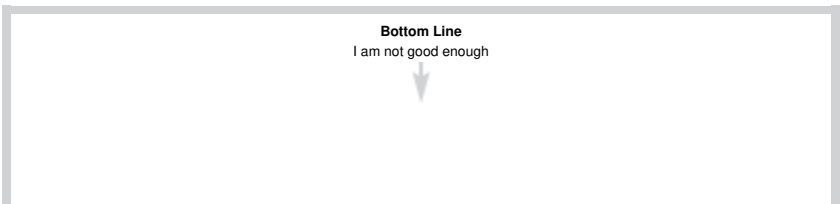
Rules like these can work very well, much of the time. For long periods, it may be possible to maintain your good opinion of yourself by obeying them. Unfortunately, however, there is a fundamental problem with this approach. Rules allow you to wallpaper over what you feel to be the real truth about yourself (your Bottom Line). But they do not change it. Indeed, the more successful they are, and the better you are at meeting their demands, the less opportunity they give you to stand back and take stock, question your Bottom Line, and adopt a more accepting and appreciative point of view. So the Bottom Line stays intact, waiting to be wheeled into place whenever your rules are in danger of being broken. You can see how this system worked for Jesse on page 208.

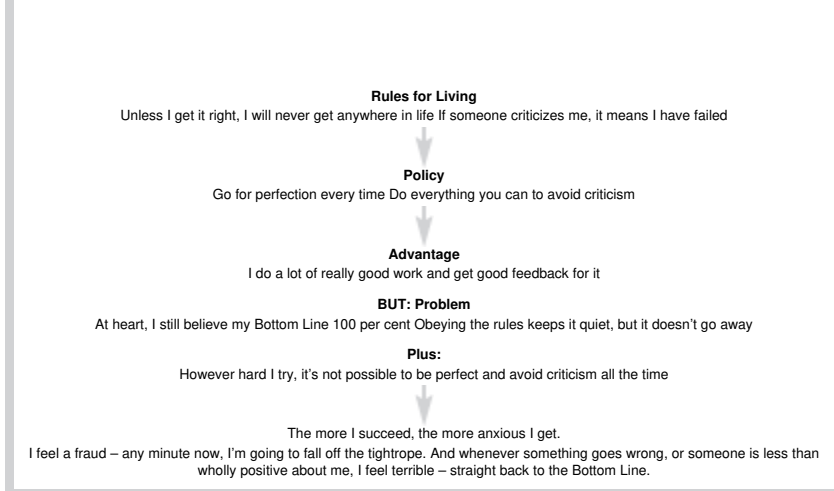
What are rules like?

Rules are learned

Unhelpful rules are rarely formally taught, but rather are absorbed through experience and observation. This is rather like a child learning to speak without learning the formal rules of grammar. As an adult, you speak grammatically (if not, you could not make yourself understood) but, unless you have made a special study of it, you are probably quite unaware of the grammatical rules you are obeying. Consequently, you might find it difficult or impossible to put them into words.

Figure 25 Rules for Living and the Bottom Line: Jesse





Personal Rules for Living are often the same – you may consistently act in accordance with them, without having ever expressed them in so many words. This is likely to be because they reflect decisions you made about how to operate in the world, when you were too young to have an adult's broader perspective. Your rules probably made perfect sense when you drew them up, but they were based on incomplete knowledge and the limited experience available to you at the time, and so may be out of date and irrelevant to your life in the present day.

Rules are part of the culture we grow up in

Rules are part of our social and family heritage. Think, for example, about gender stereotypes, the rules society has evolved about what men and women should be like. We absorb these ideas from our earliest years and, even if we disagree with them, it may be difficult to act against them. We may be punished for attempting to do so by social disapproval. The difficulties women still have in progressing in the workplace, and the struggle to establish a meaningful role for men in childcare, would be examples of this.

Personal rules are often like exaggerated versions of the rules of the society we grew up in. Western society, for example, places a high premium on independence and achievement. In a particular individual, these social pressures might be expressed through rules like 'I must never ask for help' and 'If I'm not on top, I'm a flop'. Social and cultural rules can change, and such changes (via the family) will have an impact on personal rules. In England, for example, the 'stiff upper lip' has traditionally been highly valued. In the individual, this might be expressed as: 'If I show my feelings, people will write me off as a wimp' or 'Rise above it'. More recently, however, the influence of people like Princess Diana has emphasized the importance of openly expressing vulnerability and emotion. In the individual, this might become: 'If I do not lay all my feelings on the table, it means I am hard and inhuman.' The culture from which personal rules derive operates at all levels – political systems, ethnic and religious groups, class, community, school. Whatever your background, the chances are that your personal rules reflect the culture you grew up in, as well as your immediate family.

Your rules are unique to you

Although your rules may have much in common with those of other people growing up in the same culture, no one else will exactly share your experiences of life. Even within the same family, each child's experience is different. However careful parents are to be fair to their children, each one will be treated a little differently, loved in a different way. So your rules are unique.

Rules are rigid and resist change

This is because they shape how you see things and how you interpret what happens to you on a day-to-day basis. The biases in perception and in interpretation discussed in Chapter 2 (pages 53–4) reinforce and strengthen them. Rules encourage you to behave in ways that make it difficult for you to discover just how unhelpful they are.

Think back to the work you have done on checking out anxious predictions. You saw how unnecessary precautions prevent you from finding out whether your fears are accurate. Rules work in the same way, but at a more general level. So Jesse, for example, not only strives to be '100 per cent great' when completing his high profile assignment, but in a more general sense has perfectionist standards for everything he does. This means that he has no opportunity to discover that, given his natural talents and skills, he has no real need to place such pressure on himself.

Rules are linked to powerful emotions

When you have broken the rules, and when you are at risk of doing so, your emotions will be strong. You feel depressed or despairing, not sad. You experience rage, not irritation. You react with fear, not apprehension or concern. These powerful emotions are a sign that a rule is in operation, and that the Bottom Line is gearing up for activation. In this sense, they are useful clues. However, their strength may also make it difficult to observe what is going on from an interested and detached perspective.

Rules are unreasonable

Like anxious predictions and self-critical thoughts, personal Rules for Living do not match the facts. They do not fit the way the world works, or what can reasonably be expected of the average human being. Jesse (page 208) recognizes this point when he acknowledges that it is not always possible to be perfect or to avoid criticism. We shall return to this point in more detail when we come to reformulate your personal rules.

Rules are excessive

Unhelpful rules are over-generalizations. They do not recognize that what is helpful and adaptive changes according to the circumstances in which you find yourself. They do not respond to variations in time and place, or recognize that what works in one situation or at one time of your life will not work in another. This is reflected in their language: 'always'/'never', 'everyone'/'no one', 'everything'/'nothing'. They prevent you from attending to moment-to-moment changes in your circumstances, from taking each situation on its merits, and from adopting a flexible approach and

selecting the best course of action, according to your particular needs at a particular moment in time.

Rules are absolute; they do not allow for shades of grey. Again, this is reflected in their language: 'I must . . .', 'I should . . .', 'I ought to . . .', rather than 'It would be in my interests to . . .' or 'I prefer . . .'; 'I need . . .' rather than 'I want . . .' or 'I would like . . .' This black-and-white quality may reflect the fact that they were developed when you were very young, before you had the breadth of experience to see things from a more complex perspective.

Rules guarantee continued low self-esteem

The sequence Jesse identified on page 208 illustrates an important point. He noticed that his rules required something that was in fact impossible: unflinching 100 per cent performance and never encountering criticism of any kind. This is characteristic of unhelpful rules linked to low self-esteem. They mean that your sense of your own worth is dependent on things which are impossible (e.g. being perfect, always being in full control of what happens to you), or outside your control (e.g. being accepted and liked by everyone). People hang self-esteem on a whole range of pegs:

- Being young
- Being beautiful
- Being fit and healthy
- Being in paid employment
- Being a parent
- Money
- Status
- Being at the right school
- Having a partner
- Being a particular weight and shape
- Being top dog
- Achieving success
- Being famous
- Being loved
- Having children who are doing well
- Being secure
- Being sexually attractive . . .

The list is endless. The problem is that none of these things can be guaranteed. We all get old; we all get sick from time to time; we may be damaged or disabled; we may lose our employment; our children leave home (or if they don't, that becomes a cause of concern); there are times in our lives when we have no one special to love us or when our futures are insecure; and so on. All these things are fragile, and could be taken away. This means that, if we depend on them in order to feel good about ourselves, our self-esteem is also fragile. To be happy with yourself simply for existing, just as you are, regardless of your circumstances, puts you in a far stronger position.

Identifying Rules for Living: General points

What am I looking for?

You are looking for general rules that reflect what you expect of yourself, your standards for who you should be and how you should behave, your sense of what is acceptable and what is not allowed, and your idea of what is necessary in order to succeed in life and achieve satisfying relationships. In essence, you are defining what you have to do or be in order to feel good about yourself, and what your self-esteem depends on. If you have low self-esteem, the chances are that these standards are demanding and unrealistic (more, for example, than you would expect of any other person) and that, when you explore their impact, you will discover that they actually prevent you from having a secure sense of personal worth.

What form do unhelpful rules take?

Rules for Living can usually be expressed in one of three ways: assumptions, drivers and value judgments.

1 Assumptions

These are your ideas about the connections between self-esteem and other things in life (for example, those listed on page 213). These usually take the form of ‘If . . . , then . . .’ statements (they can also be phrased as ‘Unless . . . , then . . .’). If you look back at the list of Rules for Living on page 57 in Chapter 2, you will find a number of examples of assumptions, for example:

~~If I believe~~ anyone close to me, [then] they will hurt and exploit me
~~If someone~~ criticizes me, [then] it means I have failed
~~Unless I~~ do everything people expect of me, [then] I will be rejected
~~No one~~ I do is worthwhile unless it is recognized by others (i.e.
Unless what I do is recognized by others, [then] it is not worthwhile)

Sometimes the ‘If . . . /Unless . . . , then . . .’ is not immediately obvious, but you will see it if you look carefully. For example, Arran’s ‘Survival depends on hitting back’ could be understood as an assumption: ‘*Unless I hit back, then I will be destroyed.*’

Assumptions like these are rather like negative predictions writ large. They describe what you think will happen if you act (or fail to act) in a certain way. This immediately provides a clue to one important way of changing them. They can be tested by setting up the ‘if . . .’ and seeing if the ‘then . . .’ really happens. As you learned in relation to anxious predictions, the threat could be more apparent than real.

2 Drivers

These are the ‘shoulds’, ‘musts’ and ‘oughts’ that compel us to act in particular ways, or be particular kinds of people, in order to feel good about ourselves. There are some examples of ‘drivers’ in the list on page 57:

~~I must~~ never let anyone see my true self
~~I must~~ always keep myself under tight control
~~I should~~ be able to cope with anything life throws at me

Drivers usually link up with a hidden ‘or else’. If you can find the ‘or else’, you will be able to test out how accurate and helpful they are. For Briony, the ‘or else’ was ‘they will see what a bad person I am and reject me’. For Geoff, it was ‘I will go over the top and spoil things’. For Jim, it was ‘I am weak’.

You can see from these examples that the ‘or else’ may be very close to the Bottom Line. In fact, the ‘or else’ may be a simple statement of the Bottom Line: ‘or else it means that I am inadequate/unlovable/incompetent/ugly’ or whatever. In this case, the driver is a very clear statement of the standards on which a person bases his or her self-esteem.

3 Value judgments

These are statements about how it would be if you acted (or did not act) in a particular way, or if you were (or were not) a particular kind of person. In a sense, these are rather similar to assumptions, but their terms are more vague, and may need to be unpacked to be fully understood. Examples would be: ‘It’s terrible to make mistakes’, ‘Being rejected is unbearable’, ‘It’s crucial to be on top of things’. If you find rules that take this form, you need to ask yourself some careful questions in order to be clear about the demands they are placing on you. Try to find out what exactly you mean by these vague words (‘terrible’, ‘unbearable’, ‘crucial’). For example:

- What’s ‘terrible’ about mistakes? If I did make one, what then? What is the worst that could happen? What would the consequences be?
- What do I mean by ‘unbearable’? If I imagine being rejected, what exactly comes to mind? What do I envisage happening? How do I think I would feel? And for how long?
- ‘Crucial’ in what way? What would happen if I was not on top of things? What does being on top protect me from? What is the worst that could happen if I was not? Where would that put me? What sort of person would it make me? What impact would it have on my place in the world?

How will I know when I have found my rules?

As we have said, you may never have expressed your personal rules in so many words at all. This can make them less easy to spot than anxious and self-critical thoughts which you can often observe running through your mind.

It also makes ferreting out your rules a fascinating process. You become a detective searching for clues that will give you the key to the story, an explorer hunting the map that will give you an overview of paths through the jungle. You may even feel quite surprised to discover what your rules are (‘Oh, that’s nonsense, I don’t believe that’). If this is your first reaction, stop for a moment and consider. It may be hard to believe your rule when you are sitting calmly with it written down in front of you. But what about when you are in a situation relevant to it? For example, if your rule is to do with pleasing people, what about situations where you feel you have not done so? Or if your rule is to do with success, what about situations where you feel you have failed? And what about times when you are upset and feeling bad about yourself? Even if the rule you have identified does not seem fully convincing to you in the cold light of day, do you in fact *act as if it were true*? If so, then unlikely as it may seem, you’ve hit pay dirt.

When it comes to identifying your rules, you already have a wealth of relevant information from the work you have done on anxious predictions, self-critical thoughts and enhancing self-esteem. You may already have observed that certain situations reliably spark off uncomfortable emotions and cause you problems. These are likely to be the situations relevant to your own personal set of rules.

The key situations for Jesse, for example, were times when he might be unable to perform to standard and feared he would attract criticism. Your observation of repeating patterns in your reactions may have already given you a pretty clear idea of what your rules are. If not, do not worry. If you have never put your rules into words, then it may take a while to find the right formula. Be creative and open-minded. Approach the task from different angles, using the ideas below to develop hunches about what they might be. Try different rules on for size, experiment with different wordings, and use all the clues at your disposal, until you find a general statement which seems to have been influencing you more or less consistently for some time, and which has affected your life in a range of different situations.

Identifying Rules for Living: Sources of information

You can use a number of sources of information to identify your rules. Some of these are summarized below and described in more detail on pages 220–30. You will probably find the process most rewarding and thought-provoking if you explore a range of different sources.

It is worth realizing that you may have a number of rules. Make a note of any you discover. But it is probably best to work systematically on one at a time. Otherwise, you may lose track of what you are doing. Choose a rule to work on that relates to an area of your life that you particularly want to change (e.g. relationships with other people). When you have completed the process of formulating an alternative rule and testing it out, you can use what you have learned to tackle other unhelpful rules that you also wish to change.

Figure 26 Identifying unhelpful Rules for Living: Sources of information

- Direct statements
- Themes
- Your judgments of yourself and other people
- Memories, family sayings
- Follow the opposite (things you feel really good about)
- Downward arrow

Direct statements

Look through the record you have kept of your anxious predictions and self-critical thoughts. See if you can identify any rules masquerading as specific thoughts. On reflection, do any of your predictions in particular situations reflect broader issues? Are any of your self-critical thoughts specific examples of a more general rule?

Jesse, when rushing to complete his assignment, has the thought: 'This has got to be 100 per cent great.' On reflection, he could see that this statement could also apply in many other situations – it was a general rule.

Themes

Even if no Rules for Living are directly stated in your record sheets, can you pick out continuing preoccupations and concerns? Themes that run through the work you have done? What kind of situations reliably make you doubt yourself (for example, noticing you have not done something well, or having to encounter people you are unfamiliar with)? What aspects of yourself are you most hard on? What behavior in other people undermines your confidence? Repeating themes can give you some idea of what you require of yourself, other people and the world in order to maintain your sense of self-esteem.

Sarah noticed from recording her anxious and self-critical thoughts that she was hard on herself whenever someone showed any sign whatsoever of disliking a painting she had done. On reflection, this helped her to identify a new rule: 'If someone disapproves of me, there must be something wrong with me.' Jesse, in contrast, noticed when he recorded his activities on the Daily Activity Diary that he tended to dismiss any activity which did not receive a Mastery rating of 8 or above. He realized after consideration that this black-and-white thinking reflected one of his perfectionist rules: 'If it's not 100 per cent, it's pointless.'

Your judgments of yourself and other people

Look at your self-critical thoughts. Under what circumstances do you begin to put yourself down? What do you criticize in yourself? What does that tell you about what you expect of yourself? What might happen if you relax your standards? How could things go wrong? If you do not keep a tight rein on yourself and obey the rule, where will you end up? What sort of person might you become (e.g. stupid, lazy, selfish)? What are you never allowed to do or be, no matter what?

Consider, too, what you criticize in other people. What standards do you expect them to meet? These may reflect the demands you place on yourself. Jesse, for example, noticed that he was always impatient with people who took a relaxed attitude to their work, allowed themselves lunch breaks and went home at a reasonable hour. 'Useless,' he would say to himself. 'Might as well not bother to come in at all.' This harsh judgment of other people was another clue to the high standards he set himself.

Memories, family sayings

As has been said, rules have their roots in experience. Sometimes people can trace them back to particular early memories, or to sayings that were current in the household where they grew up. Identifying these may help you to understand the policies you have adopted. Your rules may now be outdated and unhelpful, but there was a time when they made perfect sense.

When I asked for something as a child, I was often told in disapproving tones: 'I want doesn't get.' The message I took away from this was that if I wanted something, I would not be allowed to have it, or it would be taken away from me. In order to avoid disappointment, it was probably better not to want anything, and it was certainly not a good policy to be open about what you wanted.

I have realized only quite recently, since having children of my own, that 'I want doesn't get' was actually intended to convey an entirely different message: 'If you want something, say please' or, more broadly, 'Be polite'. Despite this new

understanding, I still often find it difficult to ask for what I want directly, and feel apprehensive about committing myself to want anything wholeheartedly.

This example shows how statements can have one meaning for the people who make them, and another for the people on the receiving end. What was intended as a lesson in manners was understood in a less benign way. As a child, not knowing any different, I took what I was told absolutely literally. The policy I developed as a consequence has stuck with me through thick and thin. Even insight into the difficulty and its origins has not eliminated it. As you will discover, identifying your rules is only the first step to changing them.

Think back to when you were young, as a child and in your teens, and consider the messages you received about how to behave and the sort of person you should be. When you were growing up:

- What were you told you should and should not do?
- What were the consequences if you did not go along with what you were told? What sort of person did that make you? What were you told to expect? What were the implications for your relationships with other people, or for your future?
- What were you criticized, punished or ridiculed for?
- What did people say or do when you did not make the grade, or failed to meet expectations?
- How did people important to you react when you made mistakes, or were naughty, or did not do well at school?
- What were you praised and appreciated for?
- What did you have to do or be in order to receive warmth and affection?
- What family proverbs and sayings can you remember (e.g. 'better safe than sorry', 'present pain for future gain', 'stupid is as stupid does')?

To help you search out particular memories, look at your thought records again, and pick out feelings and thoughts that seem typical to you (themes). Ask yourself:

- When did you first have those feelings, or notice yourself thinking and behaving in that way? What were the circumstances?
- When you look at something that typically makes you anxious or triggers self-criticism, does this remind you of anything in your past? Whose voices or faces come to mind?
- When did you first grasp that certain things were expected of you, or get the sense that approval or love were dependent on something you were required to do or be, rather than simply on the fact that you existed?
- What particular memories or images or sayings come to mind? Kate's desire to please, for example, was reinforced by her mother's repeated statement: 'If you're naughty, Mother won't love you any more.' She also had a clear (and still upsetting) memory of a particular time when her mother unexpectedly left the house after an argument. Kate could still see herself running down the street, begging her mother to come back, convinced that she was being abandoned.

Follow the opposite

Your knowledge of situations which you find difficult is one valuable source of information about your Rules for Living. You may also find clues by looking carefully at the times when you feel particularly good. These may be the times when you have obeyed the rules, done as you should and got the reactions from others that you need in order to feel good about yourself. You *did* reach those high standards, you *did* look absolutely stunning in every detail, everyone *did* like you, it was tough but you *did* keep things under control. So, ask yourself:

- What makes you feel really, really good?
- What are the implications of this? What rule might you have obeyed? What standards have you met?
- What qualities and actions do you really admire and value in other people? What does this tell you about how you are supposed to act or be?

Downward arrow

This is a way of using your awareness of how you think and feel in specific problem situations to get at general rules. It was first described in David Burns's book, *Feeling Good*, a self-help cognitive therapy manual for depression (pages 263–70). You will find an example (Jesse's downward arrow) on page 229. These are the steps involved:

Your starting point

Think of a kind of problem situation which reliably upsets you and makes you feel bad about yourself (for example, being criticized, failing to meet a deadline, avoiding an opportunity). These are the situations where your Bottom Line has been activated because you are in danger of breaking your rules, or have actually broken them. Now think of a recent example which is still fresh in your memory.

The details

Remind yourself what happened. On a blank sheet of paper, write down the emotions you experienced in the situation and the thoughts or images that ran through your mind. Identify the thought or image which seems to you to be most important, and which most fully accounts for the emotions you experienced.

The downward arrow

Instead of searching immediately for alternatives to your thoughts, ask yourself: 'Supposing that were true, what would it mean to me?' When you find your answer to this question, rather than trying to work out alternatives to it, ask the question again: 'And supposing that were true, what would it mean to me?' And again. Continue on, step by step, until you discover the general underlying rule that makes sense of your thoughts and feelings in the specific problem situation you started from.

'What would that mean to you?' is only one possible question you can use to pursue the downward arrow. You will find others that may be helpful in teasing out the rule behind the problem summarized on page 228.

Remember, it is possible that you have a number of unhelpful rules for living – people often do. You may find it interesting to pursue downward arrows from a number of different starting points. This is crucial if you have difficulty identifying your rule when you first do it. It is also a way of verifying that you are on the right track, and of discovering other rules within your system. Experiment with asking different questions, too. The answers may be illuminating.

Figure 27 Downward arrow questions

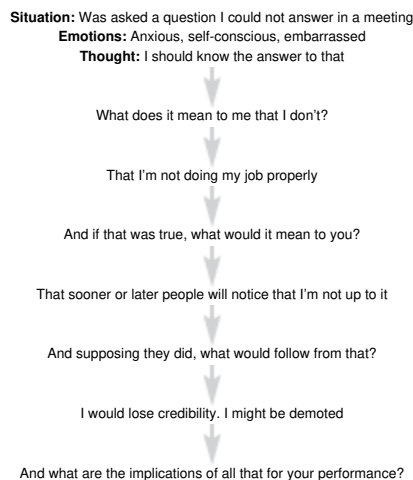
- Supposing that were true, what would it mean to you?
- Supposing that were true, what would happen then?
- What's the worst that might happen? And what would happen then? And then?
- What would be so bad about that? (n.b. 'I would feel bad' is not a helpful answer to this question. You probably would feel bad, but that on its own will not tell you anything useful or interesting about your rules. So if your immediate answer is something about your own feelings, ask yourself why you would feel bad.)
- How would that be a problem for you?
- What are the implications of that?
- What does that tell you about how you should behave?
- What does that tell you about what you expect from yourself, or from other people?
- What does that tell you about your standards for yourself?
- What does that tell you about the sort of person you should be in order to feel good about yourself?
- What does that tell you about what you must do or be, in order to gain the acceptance, approval, liking or love of other people?
- What does that tell you about what you must do or be in order to succeed in life?


If, when you do the downward arrow, you have a sense of going round in circles after a certain point, the chances are that you have reached your rule, but that it is not in a form you can easily recognize. Stop questioning, stand back and reflect on your sequence. What Rule for Living do the final levels suggest to you? When you have an idea, a draft rule, try it on for size. Can you think of other situations where this might apply? Does it make sense of how you operate elsewhere?

Try another similar starting point. Does it end up in the same place? Take a few days to observe yourself, especially your anxious predictions and self-critical thoughts. Does your draft rule make sense of your everyday reactions? If so, you are in a position to start looking for a more helpful alternative. If not, what rule might better account for what you observe? Don't be discouraged; have another go.

You may find at first that you have a good general sense of what your rule might be, but that the way you have expressed it doesn't feel quite right. Because rules are often unformulated, it may be awkward at first to get the right wording. Play around with the wording until you find a version that 'clicks' with you. Try out the different possible forms a rule can take: assumptions, drivers and value judgments. When you get the right wording, you will experience a sense of recognition – 'Aha! So that's what it is.'

Figure 28 The downward arrow: Jesse





I really can't afford not to have the answers to everything.
I've got to come up with the goods, all the time, no matter what

So what's the rule?

Unless I always get it right, I will never get anywhere in life

Assessing the impact of your Rules for Living

Rules are not like anxious predictions or self-critical thoughts. They do not pop into your head under specific circumstances at specific moments. They may influence how you think, feel and act across a whole range of different situations, and across time. As we said, you may well have learned them when you were very young.

Once you have identified an unhelpful rule, it is worth considering the impact it has had on your life. When you come to change your rule, you will not only need to formulate an alternative, more realistic and helpful Rule for Living, but also to modify its continued influence on daily living. Recognizing its impact will help you to achieve this. You will already have much of the information you need, from the work you have done on anxious predictions, self-critical thoughts and enhancing self-esteem.

Start by looking at your life now. What aspects of it does your rule affect? For example, relationships? Work? Study? How you spend your leisure time? How well you look after yourself? How you react when things do not go well? How you respond to opportunities and challenges? How good you are at expressing your feelings and making sure your needs are met? How do you know your rule is in operation? What are the clues? Particular emotions, or sensations in your body, or trains of thought? Things you do (or fail to do)? Reactions you get from other people?

Now look back over time. Can you see a similar pattern extending into your past? From a historical perspective, what effect has the rule had on you? What unnecessary self-protective policies and precautions has it led to? What have you missed out on, or failed to take advantage of, or lost, or jeopardized because of the rule? What restrictions has it placed on you? How has it undermined your freedom to appreciate yourself, and to relax with others? How has it affected your capacity for pleasure? Look back at the work you have already done in previous chapters. How much of what you have observed can be accounted for by this rule?

Consolidating your discoveries

You should now have a good sense of what your rule (or rules) might be. Consolidate by summarizing in writing what you have discovered:

- My rule is: _____
- This rule has had the following impact on my life:
- I know that the rule is in operation, because:

You may find it helpful to increase your sense of how the rule operates by watching it

in action for a few days. Collect examples (probably very similar to what you have already been recording) and fine-tune your understanding of how it influences you and how you can tell that it is in operation. Once you have identified it, you may discover it popping up all over the place.

Changing the rules

Your Rules for Living may have been in place for some considerable time. They will not change overnight. However, you are not at square one. The skills you have already mastered in dealing with anxious predictions and self-critical thoughts, in focusing on your good points and treating yourself to the good life, are all part of changing the rules. Now that you know what they are, you will move on to question the rules in their own right. You will find some helpful questions summarized on page 233 and discussed in more detail below.

Your aim is to find new rules which will encourage you to adopt more realistic standards for yourself and help you to get what you want out of life. As we said earlier, you may have discovered more than one unhelpful rule that keeps your self-esteem low (for example, you need approval and you are also something of a perfectionist). If so, start with the one you would most like to change, and then use what you learn to undermine the others. You will gain more from working systematically on one rule at a time than from jumping around from one to another, doing a little bit here and a little bit there. You may find it helpful to summarize your line of argument and how you plan to test-drive your new rule in a flashcard as discussed on page 243.

Figure 29 Changing the rules: Helpful questions

- Where did the rule come from?
- In what ways is the rule unreasonable?
- What are the payoffs of obeying the rule?
- What are the disadvantages?
- What alternative rule would be more realistic and helpful?
- What do you need to do to 'test-drive' your new rule? How can you go about putting it into practice on a day-to-day basis?

Where did the rule come from?

The purpose here is not to wallow in the past, but rather to put your rules in context, to understand how they started and what has kept them going. This is a step towards detaching yourself from them. Keep these questions in mind:

- How far does my past experience make sense of my rules?
- How well does it explain the strategies I have adopted?
- How well does it help me to understand how I operate in the present day?

You may already have a good sense of where your rules come from. Understanding their origins will help you to see that they were your best options, given the knowledge available to you at the time. This insight in itself is unlikely to produce substantial change, but it can be a helpful first step towards updating your rules for living. However, if you cannot think where your rules have come from, do not despair. This information is not essential to changing them. It just means that the

questions which follow are likely to be more helpful to you.

If you know what they are, summarize for yourself the experiences in your life that led to the rule. Remind yourself when you first noticed the cues that tell you it is in operation. Was the rule part of your family culture, or part of the wider culture in which you grew up? Did you adopt it as a means of dealing with difficult and distressing circumstances? Was it a way of ensuring the closeness and caring you needed as a child? Or of managing unkind or unpredictable adults? Or coping with the demands of school? Of avoiding teasing and ridicule?

You may also want to take account of later experiences that have contributed to keeping the rule in place. For example, have you found yourself trapped in abusive relationships? Have other people taken over the critical role your parents took towards you? Have you repeatedly found yourself in environments that reinforce the policies you have adopted? Jesse, for example, had particular problems in one job where he had a bad-tempered and critical boss. Under this pressure, he redoubled his efforts to get it right.

Granted that the rule did make sense at one point, you nevertheless need to ask yourself how relevant it is to you is it now, as an adult. If you come from a broadly Christian country, there was probably a time in your life when you believed in Santa Claus. You had every reason to do so. People you trusted told you he existed, and you saw the evidence with your own eyes on Christmas morning. It made perfect sense to adopt a policy of trying to be especially good in the days before Christmas and putting out a stocking (or pillowcase) for your presents. When I was a child, we also left a glass of brandy and a mince pie out for the old man, and some carrots for the reindeer. In the morning, nothing was left but crumbs.

But things move on, and you now have a broader experience of life and a different understanding of what happened on Christmas Eve. It is unlikely that, as an adult, you are still convinced that Santa Claus exists and behave accordingly. It would be odd if you still put out your stocking – unless, of course, you have good reason to suppose that someone else in your household will fill it, or you are playing Santa Claus for a new generation of children.

If you come from a cultural background which does not recognize Santa Claus, think of other myths or legends which you believed in as a child but which you now understand differently. Maybe the same is true of your personal rules. Are they still necessary or beneficial? Or might you in fact be better off with an updated perspective?

In what ways is the rule unreasonable?

This question is a little like questioning negative thoughts by assessing the evidence for and against them. Unhelpful rules for living are extreme in their demands. In this sense, they depart from the facts and refuse to recognize the richness and variety of experience. Call on your adult knowledge to consider in what ways *your* rule fails to take account of how the world works. How does it go beyond what is realistically possible for an ordinary, imperfect human being, or what you would expect from another person you respected and cared about? In what ways are its demands over the top, exaggerated or even impossible to meet?

Remember, this was a contract you made with yourself as a child. Would you now allow a child to run your life for you? Why not? What can you see as an adult

that you could not grasp when you were very young? Given their limited experience of life, how good are children at seeing that one situation is different from another, that what works with one person does not work with another, that everything passes, that what is true at one time and in one place may not be true at another?

What are the payoffs of obeying the rule?

However unhelpful they are in the long run, Rules for Living have genuine payoffs. These help to keep them in place. Jesse, for example, knew that his high standards did genuinely motivate him to produce excellent work, for which he was respected and praised and which had helped to advance his career. This was not something he wished to lose.

It is important to be clear about the payoffs for your own rules, because alternatives you formulate will need to give you the advantages of the old rule, without its disadvantages. Otherwise, you may be understandably reluctant to let go of the old system – after all, better the devil you know than the devil you don't.

Make a list of the payoffs and advantages of your rule. What benefits do you gain from it? In what ways is it helpful to you? And consider too what you might risk if you were to let go of it. What does it protect you from?

People often have an uneasy feeling that if they were to abandon their rules, catastrophe would follow. Jesse suspected that if he were not a perfectionist, he might never again do a decent piece of work. It felt to him as though perfectionism was the only thing that guaranteed acceptance from other people. Ideas like these can be tested out through experiments at a later stage. For the moment, the important thing is to identify payoffs and fears that keep the old rule in place.

When you have listed all the payoffs of your rule, take a careful look at them. Some of them may be more apparent than real. For example, the rule that you must always put others first may encourage you to be genuinely helpful, and dispose others to feel kindly towards you. But there is a downside: your own needs are not met, and the result can be increasing resentment and fatigue, so that in the end you are no longer in a fit state to attend to others.

Jesse realized, on reflection, that his excellent work did not in fact always guarantee acceptance. He was sometimes so driven and tense that people found him unapproachable and thought him arrogant.

Do not take the payoffs you have identified for granted. Look at them closely, and assess how far they are genuine in practice. Do the same for your concerns about dropping your rule. How do you know these things would actually happen? How could you find out?

What are the disadvantages of obeying the rule?

You have explored the payoffs; now for the downside. Examine the ways in which the rule restricts your opportunities, robs you of pleasure, contaminates and sours your relationships with other people, undermines your sense of achievement or stands in the way of getting what you want out of life. Use the information you have already collected when you were assessing its impact on your life and observing it in action from day to day.

It may help to clarify the impact of the rule on your chances of achieving the kind

of life you want for yourself. Make a list of some of your main goals in life. Examples might be: to have a satisfying career; to take pleasure in what I do; to be relaxed and confident with people; to make the most of every experience. Then ask yourself: does this rule help me to achieve these goals? Is it the best strategy for getting what I want out of life? Or does it in fact stand in my way?

Charting payoffs and disadvantages

It can be helpful to summarize the payoffs and disadvantages you have identified by taking a blank sheet of paper and drawing a vertical line down the middle. In the left-hand column, write down the payoffs attached to your rule and the apparent risks of letting it go. In the right-hand column, list its disadvantages. Weigh up the two lists and, at the bottom, write your conclusions about just how helpful your rule is to you. If you decide that, on balance, your rule is helpful and takes you where you want to go, then you need take this exercise no further. If, on the other hand, you conclude that the rule is *unhelpful*, and stands in the way of getting what you want out of life, the next step is to formulate an alternative that will give you the advantages of the old without its disadvantages.

What alternative rule would be more realistic and helpful?

New rules can transform day-to-day experiences. They allow you to deal comfortably and confidently with situations which, under the old system, would have been code violations, triggering anxiety or self-criticism. What would have been disasters become passing inconveniences. What have seemed matters of life and death become exciting challenges and opportunities. New rules open the door to achieving what you want out of life.

To help you to free up your thinking, consider whether you would advise another person to adopt your old rule as a policy. If, for example, an alien from outer space came to you for advice on how to ensure a happy and fulfilled life in your part of the planet, what would you say? Or again, would you want to pass on your rule to your children, if you had any? If not, what would you prefer their rule to be?

Your task is to find a new rule which as far as possible allows you to enjoy the payoffs of the old, but eliminates its disadvantages. The new rule will probably be more flexible and realistic than the old one, more able to take account of variations in circumstances, and to operate in terms of 'some of the people, some of the time'. It will inhabit the middle ground rather than the extremes. So it will be phrased in terms of 'I want . . .', 'I enjoy . . .', 'I prefer . . .', 'It's OK to . . .', rather than 'I must . . .', 'I should . . .', 'I ought to . . .', or 'It would be terrible if . . .' You may find that the new rule starts with the same 'if . . .', but ends with a different 'then . . .' For example, Jesse replaced 'If someone criticizes me, it means I have failed' with 'If someone criticizes me, I may or may not deserve it. If I have done something worthy of criticism, that's not failure – it's all part of being human, and there's nothing wrong with that.'

This example illustrates something typical of new rules: they are often more lengthy and elaborate than old ones. This reflects the fact that they are based on an adult's ability to understand how the world works at a deeper level and to take account of variations in circumstances. Sometimes it is nice, however, to capture

their essence in a slogan, the sort of snappy statement you might find on a badge or T-shirt. Some time after he had formulated his new rule, Jesse watched a film in which a young boy was struggling to please his father on the mistaken grounds that only something exceptional would win his approval. Jesse decided to adopt the father's loving response as a slogan for himself: 'You don't have to be great, to be great.'

You may find it difficult at first to find an alternative you feel comfortable with. Write down your best shot, and then try putting it into operation for a week or two to find out how well it works for you and if there are any ways of changing it for the better. It may also be worth your while to talk to and observe other people. What do you think their rules might be? Your observations will give you an opportunity to discover the variety of positions people adopt, and to clarify what stance might work best for you.

What do you need to do to 'test-drive' your new rule? How can you go about putting it into practice on a day-to-day basis?

Your old rule may have been in operation for some considerable time. In contrast, the new one is only fresh from the lathe, and it may take a while for it to become a comfortable fit. You need to consider what to do to consolidate your new policy, check out how well it works for you, and plan how to put it into practice on an everyday basis. This takes us back to all the work you have already done, and to the central idea of finding things out for yourself by setting up experiments and examining their outcome. The most important thing you can do to strengthen your new rule (and indeed to discover if you need to make further changes to it) is to act as if it was true and observe the outcome. The next section will provide some ideas on how to go about this.

Consolidating what you have learned

The written summary

This is a good time to complete your written summary, using the headings on page 232 if you wish. You will find an example (Jesse's written summary) on pages 247–8. You have already summarized what you discovered when you were identifying your unhelpful rule; now you can summarize what you learned when you worked on changing it.

Like your list of positive qualities and good points, a written summary on its own is not enough. The line of argument you have pursued, and the new rule you have formulated, need to be part of your everyday awareness, so that they have the best possible chance of influencing your feelings and thoughts and what you do in problem situations. So when you have completed your summary, put it somewhere easily accessible and, over the next few weeks, read it carefully every day – perhaps more than once a day, to begin with. A good time is just after you get up. This puts you in the right frame of mind for the day. Another good time is just before you go to bed, when you can think over your day and consider how the work you have done is changing things for you.

The objective is to make your new rule part of your mental furniture so that

eventually, acting in accordance with it becomes second nature. Continue to read your summary regularly until you find you have reached this point.

The flashcard

Another helpful way to encourage the changes you are trying to make is to write your new rule on a stiff card (an index card, for example) small enough to be easily carried in a wallet or purse. You can use the card as a reminder of the new strategies you aim to adopt, for example taking it out and reading it carefully when you have a quiet moment in the day, and before you enter situations you know are likely to be problematic for you.

Dealing with the old rule

Even when you have a well-formulated alternative and you are beginning to put it into practice, your old rule may still rear its ugly head in the usual situations for some while. After all, it has been around for a long time and may not just slink quietly away as soon as you expose it to the light of day. If you are prepared for this, you will be able to tackle the old rule calmly when you see it in operation, instead of getting discouraged and wondering if you will ever be rid of it. Here is where the work you have done on anxious predictions and self-critical thoughts will pay off. Remember that these are the sign that the old rule is in danger of being broken. Continue to use the skills you have learned to question your thoughts, find alternatives to them, and experiment with acting in different ways. Over time, you will find you have less and less need to do so.

Experimenting with the new rule

As well as tackling the old rule when it comes up, you need to develop a clear plan of action to help you experiment with acting in accordance with the new rule and observing the outcome. Do the 'if . . .' or 'unless . . .' and see if the 'then . . .' follows. If you look back over earlier chapters, you may well find that in fact you have already been doing so when you checked out anxious thoughts, combated self-criticism by being kinder and more tolerant towards yourself, focused on your good points, gave yourself credit for your achievements, and treated yourself to the good things in life. Examine what you have already done, and identify things which are a part of changing your rules. You can put them in your action plan.

In addition, ask yourself what else you could do to ensure that your new rule is indeed a useful policy, and to explore the impact of adopting it on your everyday life. This means expanding your boundaries, discovering that it is still possible to feel good about yourself even if you are less than perfect, even if some people dislike and disapprove of you, even if you sometimes put yourself first, or even if you are sometimes gloriously out of control.

Make sure that you include specific changes in how you go about things, not just general strategies. Not just 'to be more assertive', for example, but 'ask for help when I need it', 'say no when I disagree with someone', 'refuse requests when to carry them out would be very costly for me', 'be open about my thoughts and feelings with people I know well'. Then consider how to plan these changes into your

life. You could, for instance, use the Daily Activity Diary to plan experiments at specific times, with specific people, in specific situations.

You will also need to be sure that you know how to go about assessing the results of your experiments. This is rather like what you learned to do when you were checking out anxious predictions. What exactly do you need to be on the lookout for? What would be the signs that your new policy was paying off – or not? What would you observe in yourself (your feelings, your body state, changes in your behavior) if the new rule was working (or not)? What would you see in others' reactions to you? Just as you specified your predictions and how you would know if they were true at the thoughts level, so you need to be specific when carrying out experiments to consolidate and strengthen new rules for living.

Do not be surprised if acting in accordance with your new rule feels uncomfortable at first. You may well find that you feel quite apprehensive before you carry out experiments. If so, work out what you are predicting and use your experiment to check it out (remember to drop unnecessary precautions, otherwise you will not get the information you need). Equally, you may find you feel guilty or worried after you have carried out an experiment, even if it has gone well. This happens, for example, with people who are experimenting with being less self-sacrificing or with dropping their standards from '110 per cent' to 'good enough'. Or again, you may get angry with yourself and become self-critical if you plan to carry out an experiment and then chicken out. Again, if you experience uncomfortable feelings like these, look for the thoughts behind them and answer them, using the skills you have already learned.

Be prepared

It could take as much as six to eight months for your new rule to take over completely. As long as the new rule is useful to you and you can see it taking you in useful and interesting directions, don't give up. You may find it helpful to review your progress regularly and to set yourself targets. What have you achieved in the last week, or month? What do you want to aim at in the next week, or month?

Keeping written records of your experiments and their outcome, and of unhelpful thoughts that you have tackled along the way, will help you to see how things are progressing. You can look back over what you have done and use it as a source of encouragement. It may also be helpful to work with a friend – ideally, someone who does not share your particular rule and whose particular rule you do not share. Two heads are better than one, but not when you both have identical perspectives.

Figure 30 Changing the rules: Written summary – Jesse

- **My old rule is:**
Unless I get it right, I will never get anywhere in life.
- **This rule has had the following impact on my life:**
I have always felt inadequate, not good enough. This has made me work tremendously hard, to the extent that I have been constantly under pressure, tense and stressed. This has affected my relationships. I have not had enough time for people, and I have lost out because of it. At times, it has made me quite ill. And I have sometimes run away from opportunities because I didn't think I would measure up.
- **I know the rule is in operation because:**
I get anxious about failing and put myself under more and more pressure. I go over the top in how I go about things – try to do every 'I' and cross every 'I'. I feel sick with anxiety. And if I think I've broken the rule, I become very self-critical, get depressed, and give up altogether.
- **It is understandable that I have this rule because:**

When I was young, my father's disappointment with how his life has turned out made him very keen that we should all make the most of ourselves. Instead of encouraging and praising us, he gave us all the message that we were not up to it if we did could not perform the way he wanted us to. That message sank in, and I have tried to compensate by being a perfectionist.

- **However, the rule is unreasonable because:**

It simply is not humanly possible to get it right all the time. Making mistakes and getting things wrong are all part of learning and growth.

- **The payoffs of obeying the rule are:**

Sometimes I do really good work, and get praise for it. This is partly why I have done so well in my career. People respect me. When I do get it right, I feel great.

- **But the disadvantages are:**

I am constantly tense. Sometimes my work is not as good as it could be, because I get in such a state about it. I can't learn from my mistakes, because they upset me so much, nor can I learn from constructive criticism. When things do not work out, I feel dreadful and it takes me ages to get over it. I avoid anything that I might not be able to get right, and miss all kinds of opportunities because of that. People may respect me, but it keeps them at a distance. They see me as a bit inhuman, unapproachable – even arrogant. The pressure I place on myself is bad for my health. Plus all my time and attention goes on my work – I don't give allow myself to relax or do things to enjoy myself. In short, the rule leads to stress, misery and fear on all fronts.

- **A more realistic and helpful rule would be:**

I enjoy doing well – there's nothing wrong with that. But I'm only human and I will get it wrong sometimes. Getting it wrong is the route to growth.

- **In order to test-drive the new rule, I need to:**

- Keep reading this summary
- Put my new rule on a flashcard and read it several times a day
- Cut my working hours and plan pleasures and social contact
- Take time for myself
- Revise my standards and give myself credit for less than perfect performance
- Experiment with getting it wrong and observe the outcome. For example, practise saying 'I don't know' when people ask me questions
- Plan my day in advance, and always plan less than I think I can do
- Focus on what I achieve, not on what I failed to do. Tomorrow is another day
- Remember: criticism can be useful – it doesn't mean I am a complete failure
- Watch out for signs of stress – they mean I am going back to my old ways
- Deal with the old pattern, when it comes up, using what I have learned to tackle anxious predictions and self-criticism

CHAPTER SUMMARY

- 1 When you have low self-esteem, unhelpful Rules for Living prevent you from getting what you want out of life and accepting yourself as you are.
- 2 Rules are learned through experience and observation. They are part of the culture we grow up in, and are usually transmitted to us by our families.
- 3 Many rules are helpful. But the unhelpful rules linked to low self-esteem are rigid, demanding and extreme, restrict freedom of movement, and make change and growth difficult or impossible.
- 4 Rules represent a way of coping with the apparent truth of the Bottom Line, but they do nothing to change it. In fact, they help to keep it in place.
- 5 Unhelpful rules can be identified and changed. New, more realistic and helpful rules can be formulated and tested for goodness of fit.

Undermining the Bottom Line

Introduction

You have now laid the foundations for tackling your Bottom Line, the negative beliefs about yourself that lie at the heart of low self-esteem. Chapter 2 described how these beliefs develop. They are understandable conclusions you reached, probably as a child, on the basis of experience – opinions, not facts. Once established, they are kept in place by biases in how you perceive and interpret what happens to you, and by unhelpful Rules for Living which are designed to help you cope in the world (given the apparent truth of the Bottom Line), but which in fact merely wallpaper over your insecurities while leaving them intact. Chapter 3 described how the Bottom Line is activated in situations where your personal rules are in danger of being broken, giving rise to a vicious circle fuelled by anxious predictions and self-critical thoughts.

Chapters 4 to 7 have addressed the key elements that keep low self-esteem in place, one by one. You have learned how to check out anxious predictions, how to combat self-critical thoughts, and how to focus on your good points and treat yourself like a person who deserves the good things in life. You have formulated new, more realistic and helpful rules for living, and begun to put them into practice.

You may find that, by the time you have completed these chapters and reduced the impact of your Bottom Line on everyday life, your ideas about yourself have already changed. It may be that your old, negative Bottom Line already seems less convincing than it did, even though you have not yet challenged it directly.

Some people find that, once they have broken the vicious circle that keeps low self-esteem going and started acting in accordance with more realistic Rules for Living, the problem of low self-esteem is pretty much resolved. Others find it harder to use specific day-to-day changes in thinking and behavior to alter entrenched negative beliefs about themselves. However things stand for you at this point, this chapter will help you to consolidate what you have learned and bring it to bear on your Bottom Line.

The objective is to help you to formulate a new, more appreciative and kindly view, capitalizing on the work you have already done to help you take the final steps in your journey towards self-acceptance. These steps are:

- Identifying your old, negative Bottom Line
- Creating a new, more positive Bottom Line
- Reviewing the evidence you have used to support the Old Bottom Line and looking for other ways of understanding it

- Searching for counter evidence that supports the New Bottom Line and contradicts the old one
- Devising experiments that will consolidate and strengthen your New Bottom Line.

Identifying the Bottom Line

As you have made your way through the book, you may already have gained a very good sense of what your Bottom Line is. This section will present some possible sources of information to help you identify it clearly (a summary is on page 257). You may find it helpful to consider each source of information in turn. Each will give you a slightly different take on things, so that your idea of what your Bottom Line might be will become increasingly clear.

Even if you are already pretty sure, reviewing this section will give you an opportunity to confirm your hunches, fine-tune the wording and perhaps discover other negative beliefs about yourself that you were less aware of. It is quite possible that you have more than one Bottom Line (like Sarah, who saw herself as both unimportant and inferior). If so, do as you did with your Rules for Living. Choose the Bottom Line that seems most important to you, the one that you would most like to change, and use the chapter to work systematically on that. You can then use what you have learned to change other negative beliefs about yourself if you wish (and, indeed, to change unhelpful negative beliefs you may have about other people, the world in general and life).

Write down whatever hunches about your Bottom Line come to mind as you consider each potential source of information. When you feel you have a clear sense of what it is, summarize it for yourself ('My Bottom Line is: "I am"'). You may find it helpful to use the Summary Sheet outlined and illustrated at the end of the chapter. Then rate how far you believe it (0–100 per cent), just as you rated belief in your anxious and self-critical thoughts. One hundred per cent would mean that you still find it fully convincing, 50 per cent that you are in two minds, 5 per cent that you now hardly believe it at all, and so on.

You may notice that how far you believe your Bottom Line varies. If your self-esteem is relatively robust, you may find that your Bottom Line only becomes convincing in particularly challenging situations. If so, make two ratings: how far you believe it when it is at its strongest, and how far you believe it when it is least convincing. Alternatively, you may find that your Bottom Line is more or less consistently present and convincing. In this case, you may only need one rating, or the difference between most convincing and least convincing may be smaller.

You may also find that your degree of belief has changed since you began to work on overcoming low self-esteem. This is especially likely if you have systematically followed through the ideas for change described in previous chapters. If this is the case for you, write down how far you believed your Bottom Line before you started the book, and how far you believe it now. Consider too what accounts for any changes you have observed. Was it learning to face things that frightened you and discovering the worst did not happen? Was it learning to escape the trap of self-critical thinking? Was it making the effort to focus on what is strong and good in yourself, and beginning to treat yourself like someone who deserves the good things in life? Or was it the work you did on formulating new rules for living and putting them into practice? Or perhaps it was some combination of these. If you can spot

what helped, this will tell you what you need to continue doing for yourself.

When you have rated your degree of belief, take a moment to focus on your Bottom Line and notice what feelings emerge, just as you observed your feelings when you learned to spot anxious and self-critical thoughts. Write down any emotions you experience (e.g. sadness, anger, guilt), and rate them according to how powerful they are (0–100). Again, you may notice that, although you can still call up your Bottom Line, your feelings when you focus on it have changed. If the Bottom Line is now less convincing to you than it was, then your distress when you contemplate it should also be less intense.

Sources of information on your Bottom Line

Your knowledge of your own history

When you read the stories of the people described in Chapter 2, did any of them ring bells for you? Did any of the experiences described echo experiences you had when you were growing up? Even if not, did you find yourself thinking back to when you were young and remembering things that happened to you, and the impact they had on how you felt about yourself?

You can use these memories to clarify your Bottom Line, just as you may have used memories of earlier times to help you to identify your Rules for Living. In particular, consider:

- What early experiences encouraged you to think badly of yourself? What events in your childhood and adolescence led you to the conclusion that in some way you were lacking as a person?
- When did you first have this feeling about yourself? See if you can recall specific memories. Like Briony, when her stepfather first abused her, you may find one key memory of an event when your sense of yourself crystallized. Or it may be that (as was the case for Sarah) no one event was important, but rather there was an ongoing climate of unkindness, or disapproval and criticism, or lack of affection, or not quite fitting in.
- Whose voice do you hear when you are being hard on yourself? Whose face comes to mind? What messages did this person (or these people) give you about the kind of person you are?
- What words were used to describe you when you failed to please or attracted criticism? The words used by others may have become your own words for yourself.

Figure 31 Identifying the Bottom Line: Sources of information

- Your knowledge of your own history
- The fears expressed in your anxious predictions
- Your self-critical thoughts
- Thoughts that make it hard for you to focus on your good points and treat yourself like someone who deserves the good things in life
- The imagined consequences of breaking your old rules
- The downward arrow

The fears expressed in your anxious predictions

Think back to the work you did on your anxious predictions. It could be that your fears, and the unnecessary precautions you took to keep yourself safe, will give you clues about your Bottom Line.

- Supposing what you most feared had come true: what would that have implied about you as a person? What sort of person would that have made you? Kate, for example, felt that to ask for the money she was owed (page 93) would have demonstrated just how mean, grasping and fundamentally unlovable she was.
- And what about your unnecessary precautions? Especially if your anxieties are often about the impression you make on other people, your precautions may well have been designed to hide the real you. If so, what ‘real you’? What sort of person did you fear might be revealed if you did not take steps to protect and conceal yourself? Chris’s avoidance of challenges, for example, was designed to disguise the fact that (as he saw it) he was basically stupid.

Your self-critical thoughts

Look back over the work you did on combating your self-critical thoughts. These thoughts may be a direct reflection of your Bottom Line.

- What words did you use to describe yourself when you were being self-critical? What names did you call yourself? Look for repeating patterns and automatic knee-jerk ways of addressing yourself. What negative beliefs about yourself do your self-critical thoughts reflect?
- Are the words you use similar to words that were used about you by other people when you were small? If so, they have probably been in place since then, and may well reflect lasting beliefs about yourself rather than momentary reactions.
- When you do things that trigger self-criticism, what do those things suggest about you as a person? What sort of person would do things like that? Jim, for example, thought that his inability to quell his emotions must mean he was a neurotic wreck.

Thoughts that make it hard to accept your good points and treat yourself like someone who deserves the good things in life

Examine the doubts and reservations that came to mind when you were trying to list your good points and observe them in action, when you attempted to give yourself credit for your achievements and treat yourself kindly. Difficulties you experienced in these areas could well reflect the fact that they were not a good fit with your prevailing, negative view of yourself. Jesse, for example, recognized on reflection that his reluctance to give himself credit for what he did or allow himself time to relax reflected his belief that he was simply not good enough.

- What blocking thoughts or reservations made you reluctant to accept positive aspects of yourself as a true reflection of who you are?
- How did you disqualify or discount your good points?
- What objections did you raise to giving yourself credit for your achievements, and treating yourself to relaxation and pleasure?
- What beliefs about yourself do these doubts, reservations and disclaimers reflect?

The imagined consequences of breaking your old rules

In *Rules for Living* (page 214), sometimes the ‘then . . .’ that follows an ‘if . . .’ or an ‘unless’ is more or less a direct statement of the Bottom Line (e.g. ‘If I make mistakes, then *I am a failure*’). Go back to the rules you identified, and look at what you imagined would result from breaking them.

- If you break your Rules for Living, what does that say about you as a person?

- What kind of person makes mistakes, fails to win everyone's approval or liking or love, loses their grip on their emotions, or whatever?
- If your rule is a 'should', would the 'or else' be a reflection of you as a person (e.g. 'I should always be constructively occupied [or else I am lazy'])?

The downward arrow

You can use the 'downward arrow' technique (pages 226–29) to identify your Bottom Line. The process is much the same as the process of identifying Rules for Living, but the sequence of possible questions has a different emphasis and is designed to focus your attention on your negative beliefs about yourself, rather than your standards and expectations. The main change is to enquire what each level of questioning says *about you*, rather than what it means *to you* in terms of how you should behave and the sort of person you should be.

As before, start from a specific incident when you felt bad about yourself. Write down the thoughts and feelings that you experienced – again, it may be helpful to focus particularly on the thought which is most powerful and accounts for most of the emotion you experienced. Then, rather than searching for alternatives to your thoughts, ask yourself a sequence of questions, for example:

- Supposing that was true, what would it mean about me?
- Supposing that was true, what would it tell me about myself?
- What does that say about me as a person?
- What kind of person does that make me?
- What beliefs about myself does that reflect?
- What are the implications of that for how I see myself?

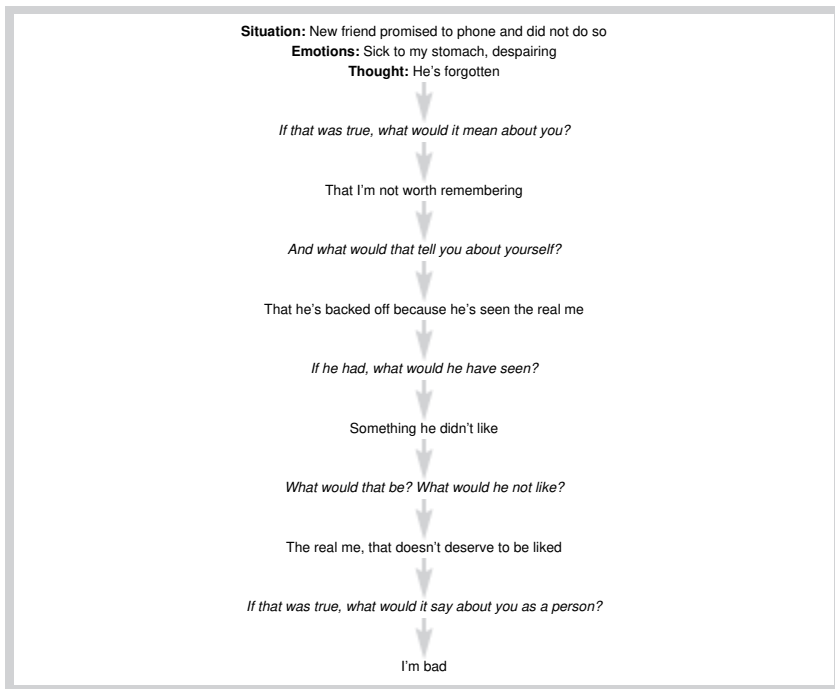
It may be helpful to use a range of different questions to help you find your Bottom Line. You are looking for a blanket statement about yourself ('I am _____'), which not only applies in the situation you are working with, but more broadly across the board. Do not stop at a specific self-critical thought, which is true at a particular moment. You should recognize your Bottom Line as an opinion you have held about yourself over time and across many different situations. You may wish to confirm your findings (or have another go, if you are having trouble finding the Bottom Line, or putting it into words) by using a number of different situations in which you typically feel bad about yourself as your starting point. You will find an example of a downward arrow leading to a Bottom Line on pages 262–3 (Briony).

Creating a new Bottom Line

Once you have identified your Bottom Line, it is worth moving on right away to formulate a more positive and realistic alternative to it, even before you begin to think it through and undermine it. This is because, over time, you have probably accumulated a sizeable bank account of experiences that seem to you to support your Bottom Line, given the biases in thinking and memory that keep low self-esteem in place. You can call on your 'Old Bottom Line Account' any time you want to, add new deposits, withdraw items and dwell on them like a miser counting and recounting money.

In contrast, you may not even have a ‘New Bottom Line Account’. Or, if you have, it may be more or less empty, and difficult to access. Items get lost in transfer, and you keep forgetting your account number and code. This means that you have nowhere safe, solid and lasting to put ‘New Bottom Line’ deposits.

Figure 32 The downward arrow: Identifying the Bottom Line – Briony



Creating a New Bottom Line opens an account in favour of yourself. It gives you a place to store experiences that contradict the Old Bottom Line and support a new, more kindly perspective. You have somewhere you can keep positive aspects of yourself safe, knowing that you can call on them when you need them.

Another way of putting this is to imagine that you have an address book with the names and contact numbers only of people who dislike you and put you down. People who like you, care about you and respect you have no place in your address book. Imagine the consequences if this was really the case. The contact numbers of people who encouraged you to feel good about yourself would be on scrappy bits of paper. They would get lost, or accidentally thrown away, or fall down behind the fridge. You might try to rely on your memory but, with so many other things to attend to, you would forget. In the end, you might not even bother to make a note of their names and numbers at all. You would know there was little point. If you wanted to start getting a more balanced perspective on how people felt about you, your first step would have to be to get yourself a new address book for the people who were on your side.

These two analogies illustrate the purpose of formulating a New Bottom Line. It gives you somewhere to put positive information about yourself, experiences that

support a more appreciative point of view. This means that you are not merely attempting to undermine your old, negative beliefs ('Maybe I'm not completely inadequate, after all'), but actively setting up an alternative and beginning to scan for information and experiences which support it ('Maybe I am adequate instead').

The work you have already done in earlier chapters, besides providing you with information about your Old Bottom Line, may also have given you some idea of what your preferred alternative might be. As you have worked through the book, checking out anxious predictions, combating self-critical thoughts, focusing on positive aspects of yourself and changing your rules, what new ideas about yourself have come to mind? When you look back over all you have done in each of these areas, what do the changes you have made tell you about yourself? Are they entirely consistent with your old negative view?

Look in particular at the qualities, strengths, assets and skills you have identified and observed, day to day. Do they fit with your Old Bottom Line? Or do they suggest that it needs updating, that it is a biased, unfair point of view which fails to take account of what is good and strong and worthy in you? What perspective on yourself would better account for *everything* you have observed? What New Bottom Line would acknowledge that, like the rest of the human race, you are short of perfect, but that along with your weaknesses and flaws you have strengths and qualities?

You are the judge and jury here, not the counsel for the prosecution. Your job is to take *all* the evidence into account, not just the evidence in favour of condemning the prisoner.

When you have a sense of what it is, write down your New Bottom Line (on the Summary Sheet at the end of the chapter, if you wish). Rate how far you believe it, just as you rated your belief in your Old Bottom Line, including variations in how convincing it seems to you and how your belief has changed since you began to work on overcoming your low self-esteem. Then take a moment to focus your attention on it, and note what emotions come up and how strong they are. As you continue through the chapter, come back to the Summary Sheet from time to time, and observe how your belief in the New Bottom Line changes as you focus on evidence which supports and strengthens it.

Looking at the examples on page 294, you will see that the New Bottom Line is sometimes simply the opposite of the old one (e.g. Karen, Geoff, Kate). In some cases, on the other hand, the New Bottom Line 'jumps the tracks', as it were, and goes off in a new direction which makes the old one almost irrelevant (e.g. Briony, Arran, Chris). Sometimes the New Bottom Line is somewhere between these (e.g. Jesse, Sarah, Jim). The point here is that your New Bottom Line should reflect a point of view that makes sense to you personally, will eventually change how you feel about yourself, and offers opportunities for a fresh perspective on your experiences which will allow you to begin noticing and giving weight to good aspects of yourself. The wording is yours.

You may find a New Bottom Line immediately springs to mind when you think back over everything you have done. Or you may find that your mind is pretty much a blank, especially if your low self-esteem has been in place for a long time and you have a strong taboo on thinking well of yourself which still needs to be challenged.

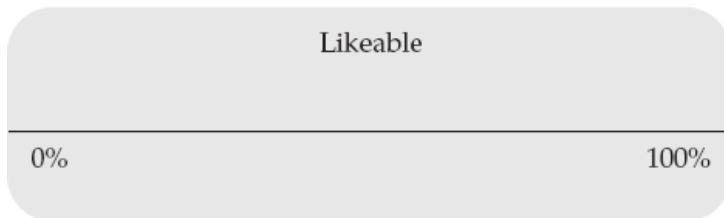
Do not worry if this is the case. Your ideas may become clearer as you work through the chapter. For the moment, it may be helpful to ask yourself a question that Christine Padesky, a cognitive therapist, suggests: 'If you were not ____ (your Old

Bottom Line), what would you like to be?’ For example, ‘If I were not incompetent, I would like to be competent.’ If you can come up with an answer to the question, however tentative, then even if it seems largely theoretical to you at the moment, write it down. It will give you a starting point for collecting evidence in favour of a new perspective (in this case, ‘I am competent’), even if it does not yet seem at all convincing to you. Conviction may come as you continue to work through the chapter.

You may find that, at this point, old ideas about the inadvisability of thinking well of yourself surface. Remember that we are not talking here about having an inflated self-image (‘I am totally wonderful in every way’, ‘Every day in every way I am getting better and better’). You are not being advised to forget your human weaknesses and flaws, to ignore aspects of yourself which you would like to change or improve on and pretend that they do not exist. This book is not about the power of positive thinking, or about encouraging you to become as unrealistically positive about yourself as you were unrealistically negative. It is about achieving a balanced, unbiased view of yourself which puts your weaknesses and flaws in the context of a broadly favourable perspective, and cheerleads for ‘good enough’ rather than ‘perfect’.

It is unlikely that you will ever be 100 per cent lovable, 100 per cent competent, 100 per cent worthy, 100 per cent intelligent, 100 per cent attractive, or whatever. Why, after all, should you be the only member of the human race, ever, who is? The work you have been doing and will do asks you to make your flaws and weaknesses simply a part of yourself, rather than a basis for your assessment of your worth. You may decide you can live with them, or you may decide you wish to change them – it is up to you.

To make this point clearer, let us consider it in relation to ‘likeable’. Imagine a 10 cm line representing likeability:



Someone at the right hand end of the line would be 100 per cent likeable. Superficially, this might appear to be a good thing. Someone at the left hand end would be 0 per cent likeable. Right now, put a ‘x’ on the line where you think you fall. If you have doubts about how likeable you are, you probably fall towards the left-hand end of the line. Now let us consider what ‘100 per cent likeable’ and ‘0 per cent likeable’ would actually mean. In order to be ‘100 per cent likeable’, you would have, for example:

- To be likeable all the time
- To be completely likeable (no aspect of you could be at all unlikeable)
- To be likeable to everyone

It will be immediately clear that 100 per cent likeable is just not possible. Nobody could be such a paragon. Think about people you know. With the extremes (0 and 100 per cent) clearly in mind, where would you put them on the line? And, again, keeping the extremes in mind, where would you now put yourself? When you decide on your New Bottom Line, keep this point in mind. You are not looking for the unattainable 100 per cent, you are looking for ‘good enough’.

Do not worry if, at the moment, your degree of belief in your New Bottom Line is low. If the Old Bottom Line has been in place for some considerable time, it will take time, patience and practice to make the new one powerfully convincing. We shall now move on to consider how to undermine your Old Bottom Line further, and how to strengthen the new one you have tentatively identified. You will find that the work you have already done will stand you in good stead here.

Undermining the Old Bottom Line

Your negative beliefs about yourself are based on experience. They represent your attempt to make sense of things that have happened to you in the past. This means that, given the biases in thinking and memory that keep them in place, as you look back over your life you will find ‘evidence’ that appears to support them. Examining this ‘evidence’ – and searching for other ways to explain it – is the next step towards overcoming low self-esteem. This is similar to the skills you have already acquired when you learned to combat self-critical thoughts, and the ideas you used at that point may also be helpful to you here. However, the scale is broader: the focus is on your general beliefs about yourself, rather than on specific thoughts that arise at a particular moment in time. The key questions to bear in mind are:

- What ‘evidence’ supports your Old Bottom Line?
- How else could this ‘evidence’ be understood?

What ‘evidence’ supports your Old Bottom Line?

I have put ‘evidence’ in quotation marks here to indicate that, although you may have accepted a range of experiences as support for your Old Bottom Line, signs that what you believed about yourself was indeed true, these experiences may in fact be open to quite different interpretations. It could be that, if you look at them closely, you will realize that they do not reflect badly on you at all. The first step towards understanding this is to identify the experiences you have been taking as supporting evidence.

Reflect for a moment on your Old Bottom Line. What experiences, past and present, come to mind? What events appear to support it? What makes you say that you are inadequate, unlikeable, incompetent, or whatever your Bottom Line may be? What leads you to reach such negative conclusions about yourself?

Supporting ‘evidence’ varies from person to person. Sometimes most of it is located in the past, in relationships or experiences like those described in the stories in Chapter 2. More recent events can also be used as sources of evidence. Some common sources of ‘evidence’ are described and summarized below. As you read, see if any of the ‘evidence’ rings bells for you.

The list is not exhaustive. The ‘evidence’ that you have used to back up your poor opinion of yourself may not be on it. Use this section nonetheless as an opportunity to reflect on what it might be. Bear in mind that you may well be using more than one source of ‘evidence’ to support your Old Bottom Line, and make a note of as many as you can find. Your next task will be to stand back and examine the ‘evidence’ carefully. When you take a good look at it, does it really confirm your negative view of yourself, or could it be understood in a different way?

Current difficulties and symptoms of distress

Briony, for example, became quite depressed at one point. As is characteristic of people who are depressed, she became lethargic and found it hard to gear herself up to do anything. Briony took this to mean that she was a lazy good-for-nothing. In other words, it was yet another sign of what a bad person she was, rather than a temporary symptom of an understandable state which would disappear once her mood lifted.

Figure 33 Sources of ‘evidence’ supporting the old, negative Bottom Line

- Current difficulties and symptoms of distress
- Failure to manage alone
- Past errors and failures
- Specific shortcomings
- Personal characteristics, physical or psychological
- Differences between yourself and other people
- Other people’s behavior towards you, past or present
- The behavior of others for whom you feel responsible
- Loss of something which was a part of your identity

Failure to overcome current difficulties alone

Jim’s difficulty in talking openly to his wife and asking for outside help is an example of this. He saw being unable to manage independently as a sign of weakness, rather than a sensible recognition that two heads are sometimes better than one.

Past errors and failures

Given human frailty, it is impossible to get through life without doing things one regrets. From time to time, we are all selfish, thoughtless, irritable, short-sighted or less than fully honest. We all take short cuts, make mistakes, avoid challenges and fail to achieve objectives. Such normal human weaknesses are often seen by people with low self-esteem as yet further evidence of their fundamental inadequacy.

This was true for Arran. During his teens, he often operated on the fringes of the law. At times, he took part in fights in which other people were hurt, once very badly. He was repeatedly in trouble with the police and appeared in court more than once. As he got older, Arran decided that this way of life was doing him no good. He was afraid to change, however, as this seemed to him the only way to survive in a hostile world. Still, he found the courage to move away from his home city, made new friends and found a job he liked, and eventually married and had children of his own. Despite these very positive changes, he still found it hard to feel good about himself.

His past haunted him. Whenever he looked back, he felt utterly worthless.

Specific problems

No one is perfect. We all have shortcomings and aspects of ourselves that we would like to change or improve. People with low self-esteem may see these shortcomings as further proof that there is something fundamentally wrong with them, rather than as specific problems which it might be possible to resolve and which bear no relation to their real worth. Every time Chris had problems with reading or writing, for example, he saw this as further evidence of his stupidity, rather than as an unrecognized specific learning difficulty which was no reflection of his intelligence and which, with proper help, could be overcome.

Physical characteristics

People with low self-esteem may feel that they are too tall, too short, too fat, too thin, the wrong colour, the wrong shape or the wrong build. They may use these observations to undermine their sense of self-esteem. Karen's belief that her worth depended on how she looked and what she weighed is an example of this. If her weight exceeded what she thought it should be, she immediately felt completely fat, ugly and unattractive. Nothing else counted. She ignored all the other things that made her attractive – for example, her sense of style, her ability to enjoy life and her intelligence.

Psychological characteristics

Psychological characteristics too can lead people with low self-esteem to feel bad about themselves. Geoff, for example, even as an adult, was afraid that his high energy, curiosity and inventiveness would be seen as showing off. Expecting disapproval and criticism, he did what he could to blend in, become part of the furniture, and dampen himself down. Instead of accepting his qualities as gifts, he saw them as further evidence that he was unacceptable.

Differences between yourself and other people

However talented you are, it is likely that there are other people who are more talented. However much you have, there are probably others who have more. People with low self-esteem may use comparisons with other people as a source of evidence to support their poor opinions of themselves. Sarah, for example, was always comparing her work to other artists'. In these comparisons, she usually felt she came off worst. Rather than judging herself on her own merits, regardless of what other people did, she used negative comparisons to fuel her sense of inferiority.

Other people's behavior towards you, past or present

People who were treated badly as children may see this treatment as evidence of their own lack of worth, whether the treatment came from family, schoolmates or the society in which they lived. Equally, dislike, rejection, disapproval or abuse in the present day can be used to bolster low self-esteem. For example, the treatment she

had received from her step-parents was Briony's main source of evidence that she was bad. Why else would they have been like that? Even as an adult, if someone treated her badly, her immediate assumption was that she must have deserved it in some way. So any unkindness or lack of consideration or disagreement became further evidence of her essential badness.

The behavior of others for whom you feel responsible

This is a particular trap for people with low self-esteem who become parents. They may blame themselves for anything that goes wrong in their children's lives, even long after the children have grown up and left home. This was true for Briony. When she discovered that her adolescent daughter had occasionally taken street drugs at parties, her immediate reaction was that this must be entirely her fault. She was a bad parent. Her own essential badness had somehow leaked out and contaminated her daughter. This perspective made it difficult for her to handle the situation constructively, to discuss with her daughter the possible consequences of what she was doing, and how best to resist peer pressure.

Loss of something which was a part of your identity

Chapter 7 (pages 212–3) showed how people hang self-esteem on a range of different pegs. If the peg on which you have hung your sense of worth is taken away, this exposes you to the full force of negative beliefs about yourself. Jesse, for example, was made redundant because the firm he worked for was going through hard times. His work was one of the pegs he had hung his self-esteem on. Although the company made it clear that they had no wish to lose him, he took the redundancy very personally. It was another sign that he was not good enough.

How else can the 'evidence' be understood?

Each source of 'evidence' that is used to support the Bottom Line is open to different interpretations, just as specific self-critical thoughts that run through your head in particular situations are open to different interpretations. Once you have identified the evidence that you feel backs up your Old Bottom Line, your next task is to examine it carefully and assess how far it truly supports what you have been in the habit of believing about yourself. Write down your conclusions on the Summary Sheet at the end of the chapter.

You may find the questions that follow (summarized below) useful to you. You will see that they relate directly to the various sources of evidence outlined above. It may also be worth your while to bear in mind the questions you used to tackle self-critical thoughts (pages 145–55). The particular questions that make sense to you will depend on the nature of the 'evidence' you use to support your Old Bottom Line.

Figure 34 Reviewing the evidence that supports your old Bottom Line: Useful questions

- Aside from personal inadequacy, what explanations could there be for current difficulties or signs of distress?
- Although it is useful to be able to manage independently, what might be the advantages of being able to ask for help and support?
- How fair is it to judge yourself on the basis of past errors and failures?
- How fair is it to judge yourself on the basis of specific shortcomings?

- How helpful is it to let your self-esteem depend on rigid ideas about what you should do or be?
- Just because someone is better at something than you, or has more than you do, does that make them better as a person?
- What reasons, besides the kind of person you are, might there be for others' behavior towards you?
- How much power do you actually have over the behavior of people you feel responsible for?

Aside from personal inadequacy, what other explanations could there be for current difficulties or signs of distress?

If this is a time when you are having difficulties or experiencing distress, rather than taking this as a sign that there is something fundamentally wrong with you, look at what is going on in your life at the moment. Is anything happening that might make sense of how you are feeling? If someone you cared about was going through what you are going through right now, might they feel similar? If so, what would you make of that? Would you assume that they, too, must be inadequate, bad or whatever? Or would you consider their reactions to be understandable, given what was going on? Even if nothing very obvious is happening in your life right now to explain how you feel, could it be understood in terms of old habits of thinking which are a result of your past experiences? If so, then perhaps you will find it more helpful to be kindly and understanding to yourself, to encourage yourself to do whatever needs to be done and to get whatever help you need, rather than making things worse by using how things are as a stick to beat your back with.

Although it is useful to be able to manage independently, what might be the advantages of being able to ask for help and support?

Like Jim, you may feel that asking for help is a sign of weakness or inadequacy. You should be able to stand on your own two feet. But perhaps being able to ask for help when you genuinely need it actually puts you in a stronger position, not a weaker one, because it may give you a chance to deal successfully with a wider range of situations than you could manage on your own. How do you feel when other people who are in difficulties come to you for help or support? Do you automatically conclude they must be feeble or pathetic? People who have difficulties in asking for help themselves are often very good at giving help to others. They do not judge others adversely. On the contrary, being able to offer help makes them feel useful, wanted and warm towards the person who needs them. This is how other people who care about you might feel about you, if you gave them half a chance.

Alternatively, you may fear (like Kate) that if you ask for help, you will be disappointed. Other people may take a dim view of it. They may refuse, or be scornful, or not be able to give you what you need. It makes sense to select people who you have no strong evidence to suppose will react in this way. That aside, the best way to test out how others will react is to try it. Work out your predictions in advance and check them out, just as you learned to do in Chapter 4.

How fair is it to judge yourself on the basis of past errors and failures?

People with low self-esteem sometimes confuse what they do with what they are. They assume that a bad action is a sign of a bad person, or that to fail at something means to be a failure in a much more global sense. If this were true, no one in the world could ever feel good about themselves. We may regret things we have done (like Arran), but it is not helpful or accurate to move on from that to complete self-

condemnation. If you do one good thing, does that make you a totally good person? If you have low self-esteem, you are unlikely to believe this. But you may make the same mistake when you do something wrong.

The belief that you are thoroughly bad, worthless, inadequate, useless or whatever may act as a self-fulfilling prophecy, making it difficult to make reparation for things you regret or to consider calmly how to change things for the better – what's the point, if it is dyed in the wool? Understanding your past failings in terms of natural human error and early learning may be more constructive. It will allow you to treat yourself more tolerantly – to condemn the sin but not the sinner.

This is not the same as letting yourself off the hook. It is a first step towards putting right whatever needs to be put right, and thinking about how you might avoid making the same mistakes in future. What you did may have been the only thing you could do, given your state of knowledge at the time. Now you can see things differently, so take advantage of your broader current perspective. And remember: you may have done a bad or stupid thing, but that does not make you a bad or stupid person.

How fair is it to judge yourself on the basis of specific shortcomings?

Just because you have difficulty asserting yourself, or being punctual, or organizing your time, or talking to people without anxiety, does it follow that there is something fundamentally wrong with you as a person? Having something about yourself that you would like to improve makes you part of the human race. If you are using specific difficulties as a basis for low self-esteem, you may be employing a double standard (see page 150). Would you judge another person with the same specific difficulty in the same way? If not, experiment with using a more tolerant approach to yourself. Again, it may help you to move forward rather than miring you in self-criticism.

Remember that your shortcomings, whatever they are, are only one side of you (your list of positive qualities may already have begun to make this clear). Albert Ellis, the originator of a form of psychological treatment called 'Rational Emotive Therapy', has used an analogy to convey this point. Imagine a basket of fruit. In the basket are a magnificent pineapple, some good apples, a rather mediocre orange or two, a bunch of grapes with the bloom still fresh upon them, some pears which are probably past their best and, lurking underneath, a banana which is completely black and rotten. Now, the question is: how do you judge the basket as a whole? It is impossible to do so. You can only judge its contents one by one. The same is true of people. You cannot judge them as a whole – you can only judge individual aspects of them, and individual things they do.

How helpful is it to let your self-esteem depend on rigid ideas about what you should do or be?

Hanging self-esteem on particular pegs, which may well not be under your control, inevitably makes you vulnerable to low self-esteem. You may have always been aware that your self-esteem was based on a particular aspect of yourself (e.g. your ability to make people laugh, your physical strength, or your capacity to earn a high salary). Or you may have only recognized what you depended on after you had lost it

(e.g. you are aging, your physical beauty has dimmed, you have retired, your family have left home). You need now to ask yourself what your worth depends on, *apart from* the one thing you have decided is your be-all and end-all.

Your list of positive qualities may be a useful starting point here. Take another look at it. How many of the qualities, strengths, skills and talents on the list depend on the peg you usually hang your self-esteem on? If you find it difficult to get a clear perspective on this, think about people you know, like and respect. Write down what attracts you to them. When you consider why you value each person, how important is the one thing your own self-esteem depends on?

Karen found this line of enquiry very helpful in reassessing the contribution of her physical appearance to her self-esteem. Many of the positive qualities she had listed about herself (sense of style, ability to enjoy life, intelligence) bore no relation to her weight or shape. On the other hand, she could see how these qualities might be compromised by the *belief* that only weight and shape mattered. It was difficult to enjoy life, for example, when she was preoccupied with eating and not eating.

She also made a list of people she liked and respected, and wrote down what she saw as attractive in each one. She had some admiration for people who were thin and fit, but it was outweighed on a personal level by other qualities such as sense of humour, sensitivity, thoughtfulness and common sense. Compared to these, physical appearance was trivial. Karen concluded that she would do better to accept and appreciate herself just as she was, fat or thin, rather than making how she thought about herself dependent on some irrelevant standard.

Just because someone is better at something than you, or has more than you do, does it make them better than you as a person?

The fact that some people are further along a particular dimension than you are (competence, beauty, material success, career progression), does not make them any better than you as people. It is impossible to be best at everything. And (apart from very specific comparisons like height, weight and income) people cannot meaningfully be compared, any more than volcanoes and porcupines can be compared. Your sense of your own worth is best located within yourself, regardless of how you stand in relation to other people.

What reasons, besides the kind of person you are, might there be for others' behavior towards you?

People with low self-esteem often assume that if others treat them badly or react to them negatively, this must in some way be deserved. This can make it difficult to set limits to what you will allow others to do to you, to feel entitled to others' time and attention, to assert your own needs, and to end toxic relationships that damage you and stand in the way of feeling better about yourself.

Taking what others think of you, or how they behave towards you, as a measure of your personal worth does not make sense for a number of reasons. For example:

- People's judgments are not always reliable. Hitler, for example, was widely revered in the 1930s and even later in his own country. History has shown this opinion to be wrong.
- The fact that someone does not like something does not mean that it has no worth. If I did not like chocolate ice cream, for example, would that make it a bad thing?

- If your opinion of yourself rests on others' opinions of you, it is difficult (if not impossible) to have any stable sense of self. If someone likes you on a particular day, then that means you are OK as a person. If the following day you have an argument and fall out, all of a sudden you are not OK. How can both of these possibly be true? You are still the same person. And again, if you were with two people, one of whom liked you and the other did not, you would then simultaneously be both OK and not OK as a person. Relying on others' opinions for your sense of self is a recipe for confusion.
- It is impossible to get everyone's approval or liking or love all the time. People's tastes are too varied. If you try to please everyone, you will be faced with constant conflicting demands. Even if you manage to please most of the people most of the time, you will still have no real sense of worth, because any moment you could displease someone or attract criticism or unkindness. Basing your good opinion of yourself on others' good opinion of you is building your house on shifting sand.

There are many possible reasons why people behave as they do. In the case of the particular person (or people) whose behavior to you seems to back up your Old Bottom Line, what reasons could there be? For example, it could be that their own early learning has made it difficult for them to behave any differently (just as children who are abused or treated violently often become abusers or violent themselves). It could be that they are behaving badly for purely circumstantial reasons (stress, pressure, illness, fear). It could be that, without them necessarily being aware of it, you remind them of someone they do not get on with. It could be that you are simply not their cup of tea. It could be that there is nothing personal about how they treat you – their manner is critical or sharp or dismissive with everyone, not just with you.

If you find it difficult to detach yourself from your usual self-blaming perspective and to think of other reasons why people behave towards you as they do, observe how you explain bad behavior or unkindness towards people other than yourself. For example, in recent years, child abuse has jumped into the headlines. When a case is reported, do you always immediately assume that the child in question must have been to blame? Or do you place responsibility squarely on the adult abuser? Similarly, if you read about intimidation, persecution, rape or assault, is it your automatic conclusion that the person on the receiving end must have deserved it? Or can you see that the perpetrator is responsible for what he or she did? Do you consider that civilian victims of war are to blame for their fate? Or do you see them as innocent victims of violence carried out by others for their own reasons? In each of these cases, is it your automatic reaction to explain what happened in terms of something wrong with the person treated badly – it must in some way be their fault? Or do you explain what happened in some other way? If so, try applying similar explanations to your own experiences.

How much power do you actually have over the behavior of people you feel responsible for?

To feel bad about yourself because someone you feel responsible for is not OK assumes a degree of power over others which, realistically, you may not have. At the relatively trivial end of the scale, if you have a supper party, you can make your home warm and welcoming, you can provide good food and drink, you can play music you know your guests are likely to appreciate, and you can ask a mix of people who you have good reason to believe will get on with one another – but you cannot guarantee that everyone will enjoy themselves. Only they can do that.

To take the more serious example of Briony's daughter, there is much Briony can do to show how distressed she is, to explain to her daughter why what she is doing may cause her harm, and to help her to think for herself rather than going along with the crowd. But she cannot (without completely removing the independence her daughter needs as a young adult) organize 24-hour surveillance and forbid her to leave the house. In other words, Briony is responsible for managing the situation in the most caring and careful way she can, but she cannot ultimately be responsible for what her daughter does when elsewhere – she simply does not have that much power.

Try to be clear about the limits of your responsibility towards other people, in the sense of separating out what you can realistically do to influence them from what is beyond your control. It is reasonable partly to base your good opinion of yourself on your willingness to meet your responsibilities. It is not reasonable to base your self-esteem on things over which you have no control.

Summary

When you have identified the evidence you use to support your Old Bottom Line and found other ways of understanding it, return to the Summary Sheet at the end of the chapter and briefly note your findings in writing. Then, once again, rate how far you believe your Old and New Bottom Lines, and how you feel when you consider them. Can you see any change? If so, what made a difference? If not, is it that you have not yet discovered a convincing alternative way of interpreting the 'evidence'? Or is there more 'evidence' that you have not yet addressed? If so, have another try.

What evidence supports the New Bottom Line and contradicts the old one?

You have identified the evidence you have used to back up your Old Bottom Line, weighed it up and looked for other ways of interpreting or explaining it. The other side of the equation is to seek out evidence that directly contradicts the Old Bottom Line and supports your new alternative. (If you have not yet defined an alternative, stick with looking for evidence that is not consistent with your Old Bottom Line.) These two different angles on undermining the Old Bottom Line are equivalent to answering self-critical thoughts and focusing on your good points. They complement each other. Additionally, just as your work on self-criticism may have helped you to re-evaluate the evidence supporting the Old Bottom Line, so the work you have done on highlighting your strengths, skills and qualities and becoming more aware of them on a day-to-day basis will help you to look in a more focused way for information that supports your New Bottom Line.

There are two main ways of collecting new evidence that supports the New Bottom Line and contradicts the old one: observation, and behavioral experiments.

1 Observation

Chapter 2 (pages 53–55) described how the Old Bottom Line is kept in place by systematic biases in perception. These make it easy for you to notice and give weight to information consistent with the Bottom Line, while encouraging you to screen out or dismiss information which contradicts it. You have already worked on correcting

this bias when you made your list of good points and set about recording examples of them in practice. You now need to consider how to go about seeking out and recording information which directly contradicts your Old Bottom Line, and supports a more generous view of yourself.

It is important to have a clear sense of exactly what you are looking for before you begin your observations, just as you learned to be specific about what you feared might happen when you were checking out anxious predictions. Otherwise, you may waste time on observations that have no real relevance to the issue you are working on, and so will do nothing to weaken the Old Bottom Line and strengthen the New. You may also miss information that could genuinely have made a difference.

The information (or evidence) you need to look for will depend on the exact nature of your Bottom Line. If, for example, your Old Bottom Line was 'I am unlikeable' and your New Bottom Line is 'I am likeable', then you would need to collect evidence that supported the idea that you are indeed likeable (for example, people smiling at you, people wanting to spend time with you, or people saying that they enjoyed your company). If, on the other hand, your Old Bottom Line was 'I am incompetent' and your New Bottom Line is 'I am competent', then you would need to collect evidence that supported the idea that you are indeed competent (for example, completing tasks to deadline, responding sensibly to questions, or handling crises at work effectively).

In order to find out what information you personally need to look for, make a list of as many things as you can think of in answer to the following related questions:

- What evidence would you see as inconsistent with your Old Bottom Line?
- What information or experiences would suggest to you that it is inaccurate, unfair or invalid?

and, conversely:

- What evidence would you see as consistent with your New Bottom Line?
- What information or experiences would suggest to you that it is accurate, fair and valid?

Make sure the items on your list are absolutely clear and specific. If they are vague and poorly defined, you will have trouble deciding if you have observed them or not. This is why 'likeable' and 'competent' above have been broken down into small elements, rather than left as global terms which might mean different things to different people.

To give you some sense of what the possibilities are, here are examples from the people you first met in Chapter 2. They are a result of each person thinking carefully about what exactly would count as supporting evidence for his or her New Bottom Line.

Figure 35 Evidence to support the New Bottom Line: Examples

	Old Bottom Line	New Bottom Line	Supporting evidence to look for
Briony	I am bad	I am worthy	<p>Things I do for other people</p> <p>Things I contribute to society (e.g. my charity work, political activism)</p> <p>My good points, day to day (from list)</p> <p>My relationships – signs that people love me (e.g. phone calls, letters, invitations, people stopping to talk to me)</p>
Jesse	I am not good enough	I am OK as I am	<p>Signs that people value what I do (smiles, praise, thanks) even when it is not up to my old standard</p>

			<p>The good things about me that are nothing to do with how I perform (e.g. enjoying being sociable, appreciating music)</p> <p>My friendships – things people say and do that show they like me for myself, not for how good a job I do</p>
Karen	I am not attractive	I am attractive	<p>All the good qualities I have that are nothing to do with physical appearance (from my list – note daily examples)</p> <p>Signs that men are interested in me (being asked out, glances of appreciation, being chatted up)</p> <p>People responding warmly to me (smiling, laughing at my jokes, people sitting next to me, looking pleased to see me)</p>
Geoff	I am unacceptable	I am acceptable	<p>Positive responses when I dare to be myself, when I indulge in flights of fancy, get loud, pursue issues to the end, give my energy full rein (people joining in, being fired by my enthusiasm, wanting to know more, asking me back, wanting to spend time with me)</p>
Arran	I am worthless	I belong	<p>Everything that shows I am a part of things (the football club, workmates inviting me out for a drink, my kids running to say hello when I come in, my wife giving me a hug)</p>

Kate	I am unlovable	I am lovable	My friends' affection for me. The practical things my parents do for me (it's their way of showing it) The good things in me that mean I am a lovable person (my loyalty, my thoughtfulness, my ability to tune into other people's needs)
Sarah	I am inferior	I am as good as anyone	My positive qualities (keep recording examples) The good things in my life, that I deserve (my apartment, my friends, the countryside I love, my new kitten)
Chris	I am stupid	I am open-minded	The way I expose myself to opportunities to learn My curiosity The fact that I am now facing my dyslexia and doing something about it
Jim	I am strong and competent I am a neurotic wreck	I am as strong and competent as needs be	Daily signs of my ability to manage my life (handling crises at home and work; running family finances; doing my job well) Recognizing when I need help and asking for it

2 Behavioral experiments

You have already gained experience of how to set up and carry out experiments to test the validity of anxious predictions, to act against self-critical thoughts, and to test-drive new Rules for Living. Now is the time to push back the walls of the prison low self-esteem has built around you, by experimenting with acting as if your New Bottom Line was true. Despite the work you have already done on rethinking your old position, you may still feel uncomfortable or even fearful of doing this. Notice what thoughts run through your mind when you contemplate operating differently, when you feel apprehensive about entering new situations, and perhaps also when you have succeeded in being your new self and then afterwards begin to doubt how well it went. The chances are, you will find anxious predictions and self-critical thoughts behind these feelings. If so, you know what to do about them.

Once again, the experiments you need to carry out depend on the exact nature of your New Bottom Line. Consider what experiences would confirm and strengthen

your new perspective on yourself. What do you need to do in order to discover that this new perspective is useful and rings true? Remember the situations you found yourself avoiding when you were working on anxious predictions, and the situations where you felt you needed to use unnecessary precautions. You have experimented with approaching what you avoided and dropping your precautions – how does what you discovered fit here? What other experiments could you carry out on similar lines?

Equally, consider the changes you made when you were learning to treat yourself kindly and build rewards and pleasures into your life. How does *that* fit with what you are doing now? Are there are other similar things you could do now to bolster your belief in your New Bottom Line? Or more of the same?

Work out in detail what someone who believed your New Bottom Line would do, how they would operate on a day-to-day basis. Make a list of as many things as you can think of in different areas of life – work, leisure time, close relationships, social life, looking after yourself. Then translate your list into specific experiments and begin to put them into practice in your daily life. Here are some more examples, to give you a sense of the variety of experiments that is possible.

Figure 36 Building a New Bottom Line – behavioral experiments: Examples

	New Bottom Line	Experiments
Briony	I am worthy	Make the first approach to people I trust, rather waiting for them to contact me Be more open about myself with people, step by step Plan treats and pleasures for myself
Jesse	I am OK as I am	Drop my standards – spend less time preparing assignments and documents. Leave minor errors and observe the impact Admit ignorance Practise saying 'I have no opinion on that'
Karen	I am attractive	Go swimming, even if I do feel fat Wear bright colours that suit me rather than hiding behind drab clothes
Geoff	I am acceptable	Stop suppressing myself – show my feelings and see how people react Express my ideas rather than waiting for someone else to speak

		Say whatever comes into my head instead of rehearsing everything
Arran	I belong	Take the risk of making the first move towards people Look for a house to buy, instead of always living in rented rooms
Kate	I am lovable	Say 'no' Ask for what I need – otherwise there's no way I'll get it
Sarah	I am as good as anyone	Act as if I was entitled to people's time and attention Look for opportunities to exhibit, rather than avoiding them Read the critics – I don't have to agree with what they say
Chris	I am open-minded	Make up for lost opportunities – look into adult education and see what facilities there are for people with dyslexia Tell people about the problem instead of trying to pretend it does not exist
Jim	I am as strong and competent as need be	Make a point of asking for help, even when I do not really need it When something upsets me, talk about it

Summary

It will be important to record what you observe at this stage. Make sure, too, that you assess the outcome of your experiments carefully, just as you assessed the outcome of experiments when you checked out your anxious predictions. Keeping a careful record of what you notice and of exactly what you did and how it turned out will allow you to accumulate information consistent with your New Bottom Line. You could, for example, write this information down in your Positives Notebook, along with examples of your good points. If you do not record it, it may be forgotten or lost, and will not be available to you in the future when you feel doubtful about yourself.

To conclude, turn again to the Summary Sheet at the end of the chapter, and summarize what you have discovered by seeking out evidence consistent with your New Bottom Line. Then once again rate your belief in both the old and the new, and assess their impact on your feelings. Repeating these ratings regularly as you continue to undermine your Old Bottom Line and collect evidence in favour of your New Bottom Line will allow you to see how they continue to change, over time.

Taking the longer view

Building and strengthening a New Bottom Line does not happen overnight. It may take weeks (or even months) of systematic observation and experimentation before you find the alternative you have identified fully convincing. You have accumulated a lifetime of evidence that supports the Old Bottom Line, collected and stored it, mulled it over and mused on its implications for yourself. You will not need a similar lifetime of evidence in support for your New Bottom Line (that would be a discouraging thought!). But you should expect to make some investment in time and energy, some regular commitment to record-keeping and practice, in order to reach the point where thinking and acting in accordance with your New Bottom Line becomes second nature. When you reach this point, you will have made the final step towards overcoming low self-esteem. The final chapter of the book will give you some ideas on how to do this.

CHAPTER SUMMARY

1

The final step towards overcoming low self-esteem is to identify in your own words your Bottom Line. There are a number of different sources of information you can use to do this.

2

Once you have identified the old, negative Bottom Line, you can move on right away to formulate a more positive, balanced alternative. This will help you to begin noticing information you have screened out and discounted which contradicts your old beliefs about yourself.

3

The next step is to identify the evidence you have used to support your Old Bottom Line, and to examine whether you can find other ways of understanding it than assuming it reflects your real self.

4

Your final task is to decide what experiences and information would support your New Bottom Line and to begin to seek them out, both through observation and by experimenting with acting as if your New Bottom Line was true, and observing the results.

Figure 37 Undermining your Bottom Line: Summary sheet

- My Old Bottom Line is: 'I am _____'

	Belief	Emotions (0–100)
When the Old Bottom Line is most convincing:	_____ %	_____
When it is least convincing:	_____ %	_____
When I started the book:	_____ %	_____

- My New Bottom Line is: 'I am _____'

	Belief	Emotions (0–100)
When the New Bottom Line is most convincing:	_____ %	_____
When it is least convincing:	_____ %	_____
When I started the book:	_____ %	_____

- 'Evidence' supporting the Old Bottom Line and how I now understand it:

'Evidence'

New understanding

In the light of this new understanding, I now believe my

Old Bottom Line: _____%

In the light of this new understanding, I now believe my

New Bottom Line: _____%

<ul style="list-style-type: none">Evidence (past and present) which supports my New Bottom Line: <div><hr/><hr/><hr/><hr/><hr/><hr/><hr/><hr/></div> <p>In the light of this evidence, I now believe my Old Bottom Line: ____%</p> <p>In the light of this evidence, I now believe my New Bottom Line: ____%</p>
<ul style="list-style-type: none">Observation: Information and experiences I need to be alert to, in order to gather more evidence to support my New Bottom Line: <div><hr/><hr/><hr/><hr/><hr/><hr/><hr/><hr/></div>
<ul style="list-style-type: none">Experiments: Specific things I need to do, in order to gather more evidence to support my New Bottom Line: <div><hr/><hr/><hr/><hr/><hr/><hr/><hr/><hr/></div>

Figure 38 Undermining your Bottom Line: Summary sheet – Briony

- My Old Bottom Line is: 'I am *bad*'

	Belief	Emotions (0–100)
When the Old Bottom Line is most convincing:	70%	Despair 75 Guilt 60
When it is least convincing:	45%	Despair 50 Guilt 40
When I started the book:	100%	Despair 100 Guilt 100

- My New Bottom Line is: 'I am *worthy*'

	Belief	Emotions (0–100)
When the New Bottom Line is most convincing:	50%	Hope 30 Relief 40
When it is least convincing:	20%	Hope 10 Relief 10
When I started the book:	0%	Hope 0 Relief 0

- 'Evidence' supporting the Old Bottom Line and how I now understand it:

'Evidence'

My parents died – blamed myself

My step-parents' behavior

My stepfather's abuse

My first marriage – husband ridiculed and criticized me constantly, wore me down

New understanding

They loved me dearly and would never have left me if they could have helped it

Not my fault – their behavior was vicious and cruel, and there was no reason for it.

No child deserves to be treated like that

It was a wicked thing to do. He knew it: that is why he concealed it. He was the adult; I was the child. He should never have abused my trust like that. It was sick

I now know he was like that in other relationships. Given what had already happened to me, I was in no position to fight back. My belief that I was bad was a self-fulfilling prophecy: I thought I deserved it

People being irritable or unkind or putting me down *Bound to happen sometimes – can't please everyone. Does not mean I am bad*

In the light of this new understanding, I now believe my

Old Bottom Line: 30%

In the light of this new understanding, I now believe my

New Bottom Line: 75%

• Evidence (past and present) which supports by New Bottom Line:

My parents loved me. I know that from my own memories and from photos and things I have

My grandmother loved me. She couldn't protect me but she made me feel worthwhile and lovable

I made some friends at school, though I was too prickly and unhappy to have many (not my fault)

Even when I was being abused in my first marriage, I managed to hold down a job, and then, after having the children, I protected them from their father. When he began to show signs of abusing them I got the courage to leave, even though I never thought I would make it alone

I found a second husband who loves and supports me. He is a good man, and he chose me and stuck by me in spite of all my difficulties

I have struggled to overcome what happened to me, and made a good fist of it

All the good points on my list

In the light of this evidence, I now believe my Old Bottom Line: 20%

In the light of this evidence, I now believe my New Bottom Line: 85%

• Observation: Information and experiences I need to be alert to, in order to gather more evidence to support my New Bottom Line:

Things I do for other people, especially all the time and care I put into the children. My love for them, and for my husband. The pleasure I take in them.

My creativity and imagination in looking after them and helping them to develop into good people

Things I contribute to society (my charity work, my political activism)

My good points as they show themselves day to day

My relationships – signs that people love me such as phone calls, letters, invitations, people stopping to talk to me and wanting me to get involved in things

My intelligence – at last I am starting to think I am worth educating, and doing something about it

- Experiments: Specific things I need to do, in order to gather more evidence to support my New Bottom Line:

Begin making the first approach to people I trust, rather than leaving it up to them

Be more open about myself with people, step by step – see if they really do back off

Plan treats and pleasures for myself – I deserve it

Make time to study. Start saving for a proper course

Give more responsibility to the others at home to keep the show on the road

Look for a better job, one which really uses what I have got to offer

Pulling it all together and planning for the future

Introduction

In the course of working through this book, you have tackled the various thinking habits that keep low self-esteem going, and you have formulated new rules for living and a new Bottom Line and considered how to put them into practice and act as if they were true on a day-to-day basis. In this chapter, the practical ideas for overcoming low self-esteem that you have been working on will be related back to the flowchart in Chapter 2 (page 33), so that you can see how what you have been doing fits with the cognitive understanding of low self-esteem that was your starting point. We shall then move on to consider ways of ensuring that the changes you have made are consolidated and carried forward, rather than left behind when you close the book. The chapter will close with some ideas on how to seek outside help if you find the ideas you have read about here interesting and relevant, but feel you need someone to help you to put them into practice successfully.

Overcoming low self-esteem: Where does everything fit?

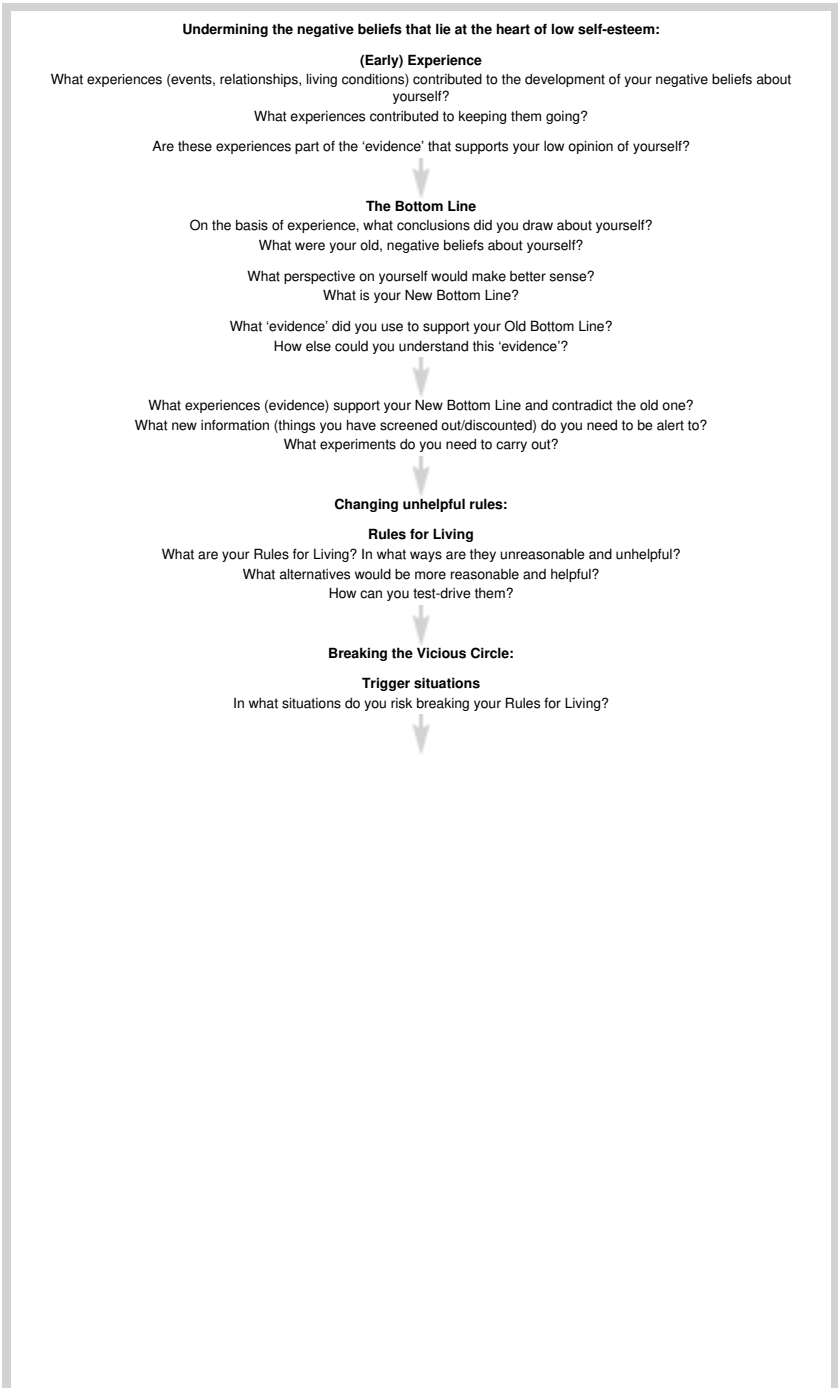
On pages 305–6, you will find the flowchart that explains the development and persistence of low self-esteem. You are already familiar with this, from previous chapters. Here, however, instead of describing how low self-esteem develops and what keeps it going, you will see that the different methods you have used to undermine your Old Bottom Line and to establish and strengthen a New Bottom Line have been entered under the different headings. This is so that you can see clearly how the changes you have made fit together as parts of a coherent plan for overcoming low self-esteem. The cognitive behavioral understanding of low self-esteem, illustrated in the flowchart, consistently emphasizes the influence of thoughts and beliefs on everyday feelings and behavior. This emphasis has informed each step of the route you have followed.

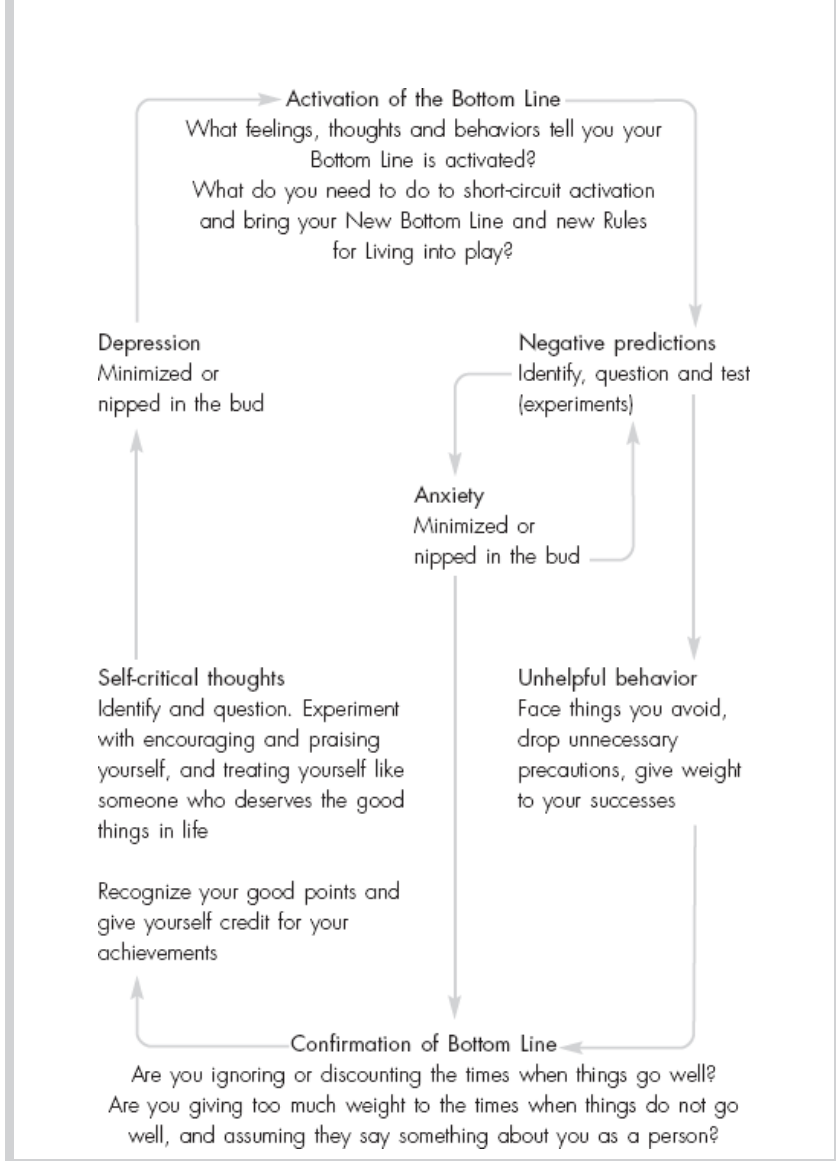
Planning for the future

You may have been highly successful at dealing with anxious predictions and self-critical thoughts, focusing on positive aspects of yourself and treating yourself to relaxation and pleasure, and formulating and acting on new rules and a new, more generous Bottom Line. However, it is possible that, unless you continue to put what you have learned into practice on a regular basis, what now seem like blinding

insights will become vague and hard to credit, and your new ways of treating yourself more kindly will decay.

Figure 39 Overcoming low self-esteem: A map of the territory





As we have said before, old habits die hard. Particularly at times when you are stressed or pressurized, or when you are feeling low or unwell or tired or under par, you may find that, with the best will in the world, your Old Bottom Line will surface again, and along with it your harsh and unforgiving standards for yourself, and your old habits of expecting the worst, screening out positives and focusing on negatives, criticizing yourself and forgetting to treat yourself to the good things in life will begin to re-establish themselves.

There is no need to worry about this. After all, you now know how to break the vicious circle that keeps low self-esteem going, and you have established and practised new Rules for Living and a New Bottom Line. It will simply be a question

of going back to what you already know and practising it systematically until you have got yourself back on an even keel. If you have a healthy awareness that a setback could occur, you will be in the best possible position to spot early warning signals that your Old Bottom Line is resurfacing and to deal with it without delay. You may be able to put it back in its place almost immediately (with little more than 'Uh-oh, here I go again' and a swift change of gear). Or it may take you a little time.

Either way, the experience will be a valuable one. It will give you an opportunity to discover again that your new ideas and skills can work for you, and to work at fine-tuning your new, positive perspective on yourself. By planning ahead and considering how setbacks might come about and what to do with them, you will ensure that the changes you have made endure in the longer term.

Alternatively, you may feel that you have learned a lot, but that new ways of thinking and acting towards yourself are still fragile. This is especially likely to be true for you if your low self-esteem has been in place for many years, and if it has had a substantial impact on your life. Here again, it will be worth your while to summarize what you have learned, to look ahead and plan how to consolidate it so that it continues to influence how you go about your daily life, strengthening your conviction in your New Bottom Line and ensuring that changes you have made are carried forward in the longer term.

In the section that follows, you will find some questions to help you to formulate an action plan for the future (see page 311 for a summary, and pages 326–8 for an illustrative example). These questions are designed to help you to make a short summary of key points you have learned, to consider how best to continue putting new ideas into practice on a daily basis, and to prepare for setbacks so that you can manage them in the best possible way.

Steps towards a water-tight action plan

The first draft

Write your answers to the questions down, together with any other helpful points that occur to you as you follow them through. This is the first draft of your Action Plan. When you have completed the draft, review it and see if you have left anything important out. Go back through the book, and any records you have kept, to remind yourself of everything you have done. When you are satisfied that you have the best possible version for the time being, put your Action Plan into practice for two or three weeks.

The second draft

Two or three weeks of putting your first draft into practice should give you a good idea of how helpful your Action Plan is. Now is a good time to review it and refine it, if you wish to do so. You may find that you have omitted something crucial, or that things arise that you have not bargained for, or that what seemed clear to you when you wrote it down seems less helpful to you when you try to apply it in real life, or when you look back on it after a time.

Make whatever changes seem necessary to you, and then write out a revised version for a longer test-drive. Decide for yourself how long you will practise

applying this version – three months? Six? You need long enough to find out how helpful the plan is in the longer term. You need an opportunity to discover how well-established your New Bottom Line is, and how consistently it influences how you feel about yourself in everyday life. You also need some sense of how well your Action Plan helps you to deal with ups and downs, and times when the old Bottom Line resurfaces.

The final draft

After a longer period of practice, once again conduct a thorough review of your Action Plan. How helpful has it been to you? How well did it keep you on track? Has it enabled you to continue to grow and develop? Has it ensured that you have dealt with setbacks in the best possible way?

If all is well, your second draft may be your final draft. If, on the other hand, your Action Plan still has shortcomings, make whatever changes are necessary, and test-drive your new version for a limited period you agree with yourself. Then review again.

It is worth noting that, unless you have superhuman powers to foretell the future, your Action Plan will never cover everything. Even your final draft will still be a *draft*, not an ultimate truth engraved on tablets of stone. However good a fit it is, and however helpful, be prepared to change and fine-tune it at any future point where you realize it could be extended, elaborated or improved.

Getting SMART

When devising an Action Plan, it is important to ensure that what you plan to do will get you where you want to go. If your plan is too ambitious, you will not be able to put it into practice successfully, and this is likely to discourage and demoralize you. If your plan is too vague, you may find that after a week (or month) or two you have no real idea of what you are supposed to be doing. If your plan is too limited, you may feel as if you are not making any real progress towards becoming the person you want to be. So, whichever stage you are at – first or second or final draft – make sure that your Action Plan meets these **SMART** criteria:

Figure 40 Action planning: Smart criteria

Simple and Specific enough?
Measurable?
Agreed?
Realistic?
Timescale reasonable?

S Is it simple and specific enough?

Can you explain what you plan to do in words of one syllable? Is it so straightforward that even a child could understand it? To check this, try reading it out to a trusted friend or a member of your family. Do they ask you to explain or clarify any part of it? If so, that part of it needs redrafting. When you have redrafted it, check out how it sounds to them now.

M Is it Measurable?

How will you know when you have achieved what you set out to do? For example, in six months' time, if you have successfully acted on your action plan, how will you be feeling? Which of your new habits will still be in place? What specific targets will you have reached? How will you know that your New Bottom Line is still going strong? And if you still have changes to make, what will you be doing then that you are not doing now?

If you can specify clearly what you are going for, it will make it much easier for you to judge whether your plan is within your grasp, to observe how well you are doing at putting it into practice and where it falls down, and to assess how helpful it is to you.

A Is it Agreed?

Have you taken into account the opinions and feelings of people who will be affected by your plan? Do you have their agreement (or at least their understanding) of what it implies? I do not mean by this that you should only proceed if other people are in favour of what you are trying to do – you do not need permission to feel better about yourself and make changes in your life that will improve your self-esteem. However, it is worth acknowledging that changes in you will mean changes for other people. For example, if you are planning to become more assertive about voicing your opinions and getting your needs met, then this will inevitably have an impact on those around you. If you are planning to change how you organize your working life (e.g. to reduce your working hours, in the interests of having more leisure and social time, or looking for more challenging assignments), then again this will have an impact on other people, both at work and at home.

When you make your Action Plan, it is important to take this into account. Are there things about your intentions that you need to communicate to others? Would it help to negotiate some of the changes you want with your nearest and dearest? What about asking for help in sticking to your plan?

And, even if you do not wish directly to involve others, consider what impact changes in you will have on them. Are they likely to react negatively in any way? What do you predict? You could, of course, be wrong – but you will be in a stronger position to stay on course if you have considered what might realistically happen, and planned how you will deal with it (if necessary, with outside support).

Part of Briony's plan, for example, was to give herself more time to do things she enjoyed. She realized that this meant she could not continue to manage domestic tasks single-handedly. In order to feel like a good mother, she had always felt she must do all the shopping, cooking, washing and cleaning for her family, even though her husband was quite capable of helping her out and her children were now old enough to contribute.

Briony realized that she had educated her family to leave all the housework up to her. She decided that it would be a good idea to fill them in on the work she had been doing to improve her self-esteem, and to tell them that she planned to start a fairer system of sharing the housework. She predicted that, in theory, her family would be able to see the justice of this, and would be in favour of what she was trying to do. She also predicted that, in practice, they would be reluctant to do their bit and would understandably prefer to leave things as they were. After all, why soil your hands if

you have a servant willing to do the dirty work for you? So, in her plan, she included careful details of what to do when her family failed to change along with her. This included reminding herself of her reasons for making the change: she was a worthy person who deserved more out of life than to be a skivvy.

R Is it Realistic?

When you plan ahead, take into account:

- Your state of emotional and physical health and fitness
- Your resources (e.g. money, time, people who care about and respect you)
- Other demands on your time and energy, and
- The level of support you have from friends, family, colleagues and others (for example, groups you belong to, such as a woman's group or a church fellowship group).

Your Action Plan will be most solid and realistic if it takes account of these factors. In addition, it will be most helpful to you if it is written up on one or two pages at the most. The longer and more elaborate it is, the less likely you are to return to it and use it as time goes on. If there are points you want to go into in more detail, put them on a separate sheet which you can refer to in the Action Plan and keep along with it.

T Is the Timescale reasonable?

Finally, make sure that you have considered carefully how much time you are willing to devote to putting your Action Plan into practice, and what timescale makes sense for achieving whatever targets you have set yourself. This may well include deciding what changes are most important to you, and which are less of a priority. Ask yourself:

- What are your priorities? If you could only complete 20 per cent of your plan, which 20 per cent would you want it to be?
- How much time every week do you need to ensure that your Action Plan becomes a reality? If you believe it would still be helpful to you to be regularly writing down and questioning your thoughts, how much time will you need to set aside every day so as to ensure that you do this is the most helpful way and without feeling pressurized or rushed? (This may involve deciding how many examples you wish to work on every day.) You may, on the other hand, be at the stage of tackling upsetting thoughts in your head by now, and be routinely noticing evidence that supports your New Bottom Line without needing to write it down. Even so, it could be helpful to plan regular reviews. How much time might you need every week (or month) to assess how things are going and set yourself new challenges to master?
- What are your personal objectives, as far as self-esteem is concerned? Where do you want to be after three months? After six months? After one year?
- How frequently will you review progress (successes, difficulties, what helped you, and what got in your way)?
- Have you set a date for your first review? This could be next week, or next month, or further away. Whenever it is, decide on a definite date and make an appointment with yourself. Make your review a special occasion. Take yourself out for lunch, give yourself a day out in the country, or at a health spa, or at the seaside. At the very least, find a peaceful space in your house, somewhere you feel comfortable and at ease, and choose a time when you will not be interrupted. Create a relaxed space where you can reflect on what you have achieved and think ahead.

Write down the date and time of your review in your diary or on your calendar right now. And do not allow yourself to put it off or be diverted. This is something you are doing for yourself. It is important. And you deserve it.

A note of caution

Action Plans can be filed away and forgotten. If you do not know where it is, you will not be able to make use of it. Leaving it lying around to end up all stained and dog-eared is like a message to yourself that it does not really matter. So make sure that you know where your Action Plan is, and that you can find it easily when you need to. Put it somewhere special, if you can: somewhere that is yours and yours alone.

Action planning: Helpful questions

Figure 41 Action planning: Helpful questions

- 1 How did my low self-esteem develop?
- 2 What kept it going?
- 3 What have I learned as I worked my way through the book?
- 4 What were my most important unhelpful thoughts, rules and beliefs? What alternatives did I find to them?
- 5 How can I build on what I have learned?
- 6 What might lead to a setback for me?
- 7 If I do have a setback, what will I do about it?

1 HOW DID MY LOW SELF-ESTEEM DEVELOP?

Briefly summarize the experiences that led to the formation of your Old Bottom Line. Also include later experiences that have reinforced it, if this is relevant.

2 WHAT KEPT IT GOING?

In response to this question, summarize the unhelpful Rules for Living that you developed as an attempt to cope with your Bottom Line, and the thinking that fuelled your vicious circle (anxious predictions and self-critical thoughts that have been typical of you). Also include any biases in what you noticed and gave weight to. What did you automatically screen out, ignore or discount? Finally, note unnecessary precautions and self-defeating behavior that prevented you from discovering that your predictions were not accurate and conspired to keep you down.

3 WHAT HAVE I LEARNED AS I WORKED MY WAY THROUGH THE BOOK?

Make a note of new ideas you have found helpful (for example, ‘My beliefs about myself are opinions, not facts’). Also include particular methods you have learned for dealing with anxious and self-critical thoughts, rules and beliefs (for example, ‘Review the evidence and look for the bigger picture’, ‘Don’t assume – check it out’). Look back over what you have done and make a note of whatever made sense to you, and whatever you personally found useful in practice.

4 WHAT WERE MY MOST IMPORTANT UNHELPFUL THOUGHTS, RULES AND BELIEFS? WHAT ALTERNATIVES DID I FIND TO THEM?

Write down the anxious predictions, self-critical thoughts, Rules for Living and Bottom Lines which caused you most trouble. Against each, summarize the alternative you have discovered. You may find it helpful to do this on a separate sheet if you have a number of items which it would be useful to summarize. You could use this format:

Unhelpful thought/rule/belief	Alternative
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

5 HOW CAN I BUILD ON WHAT I HAVE LEARNED?

Here is your opportunity to think ahead and consider in detail what you need to do, in order to ensure that the new ideas and skills you have learned are consolidated and made a routine part of how you go about your life. This is also your chance to work out what changes you still want to make. This could include going back to particular parts of the book and working through some sections again, or using the methods you have learned to change unhelpful Rules for Living or beliefs about yourself that you have not yet addressed. It might also include further reading, or a decision to seek help in order to take what you have discovered further or put it into practice more effectively (see below).

Specifically, taking it chapter by chapter:

- Are there parts of your understanding of how your low self-esteem developed and what kept it going that you do not yet understand fully? If so, how could you go about clarifying them?
- Are there still situations where you feel anxious, but you are not clear why? If so, what do you need to do to get a clear perspective on the predictions you make in those situations? Are there situations where you understand very well what your predictions are, but you have not yet faced them fully without dropping all your unnecessary precautions? If so, how could you make a step-by-step plan to tackle them? Even if you have successfully faced the situations that made you anxious and discovered that your predictions were unrealistic, it could well be that you will experience other anxieties in the future (indeed, it would be extraordinary if this were not the case, since anxiety is a normal part of human experience). How will you use what you have learned to deal with future anxieties?
- How will you ensure that you continue to extend your ability to spot and challenge self-critical thoughts? What self-defeating behaviors do you still need to watch out for? What do you plan to do instead?
- How good are you at keeping your good points in mind and noticing examples of your qualities, strengths, skills and talent on a day-to-day basis? Do you still need to keep a written record? Even if you do not, might it be nice to do so? Might it also be a useful resource to look over, if you have a setback at some point in the future?
- When you look at the pattern of your day and your week, are you achieving a good balance between 'M' activities (duties, obligations, tasks) and 'P' activities (pleasure, relaxation)? If so, how will you ensure that you continue to do so? And if not, then what do you need to do to build on changes you have already made?

- Are you routinely giving yourself credit for what you do and appreciating your achievements? If so, how can you ensure that you continue to do so? If not, why not? Are self-critical thoughts creeping in, for example, or are you still hanging on to perfectionist standards for yourself? If so, what do you need to do about it?
- How convincing do you now find your new Rules for Living? How easy is it to put them into practice? If they make complete sense to you, and you have no difficulty in acting in accordance with them, then how can you ensure that this continues to be the case, even when the going gets tough and circumstances trigger off the old rules? How far should you still deliberately be acting against the old rules and observing the consequences? How frequently should you read your 'Changing the Rules Summary Sheet', in order to ensure that what you have written stays fresh in your mind? If you still have some doubts about your new rules or find it difficult to put them into practice, what do you need to do to strengthen their credibility and make acting on them second nature? What experiments do you still need to carry out? What thoughts are getting in your way, and how can you tackle them?
- How far do you now believe your New Bottom Line? And your old one? How far are you able to act as if the New Bottom Line was true? If you believe the New Bottom Line strongly and act routinely as if it was true, how can you ensure that it stays rock solid, even in times of pressure or distress? What information do you need to continue to notice (even if you no longer routinely write it down)? What experiments do you need to continue to carry out and make a part of your life? How frequently should you read your 'Bottom Line Summary Sheet', so as to ensure that it remains at the front of your mind?

6 WHAT MIGHT LEAD TO A SETBACK FOR ME?

Consider what experiences or changes in your circumstances might still cause you problems by activating your Old Bottom Line. Your knowledge of situations that have activated your Bottom Line in the past will be helpful here (see Chapter 3, page 63). You are probably in a position now to deal with these situations much more constructively. However, supposing you were confronting a high level of stress, or your life circumstances had become very difficult, or you were tired or unwell or upset for some other reason, this might still make you vulnerable to self-doubt. Working out what your own personal vulnerabilities might be will prepare you to notice quickly when things go wrong and do something about it.

7 IF I DO HAVE A SETBACK, WHAT WILL I DO ABOUT IT?

The first, crucial thing is to notice what is happening. Consider what cues would tell you that your Old Bottom Line was back in operation. How would you expect to feel? What might be going on in your body? What thoughts would be likely to be running through your mind? What images would appear in your mind's eye? What would you notice about your own behavior (e.g. beginning to avoid challenges, dropping pleasurable activities, ceasing to stand up for yourself and meet your own needs)? What might you notice in others (e.g. irritation, reassurance, apologies)? Make a note of what you think would be strong signals that your self-esteem was beginning to dip.

The next thing is to consider in detail what you should do if you do find a setback beginning. The first thing to say to yourself is the emergency instruction from Douglas Adams's *Hitch Hiker's Guide to the Galaxy*: DON'T PANIC. It is quite natural to have setbacks on your journey towards overcoming low self-esteem, especially if the problem has been with you for a long time.

This does not mean that you are back to square one, or that there is no point in doing anything further to help yourself. On the contrary, you simply need to return to

what you have learned and begin putting it into practice systematically, until you have got yourself back on an even keel. This may mean going back to basics – for example, starting to write things down regularly again, perhaps after you have stopped needing to do so for some time. This may feel like a backwards step. In fact, it is simply a sensible recognition that, for a limited period, you need to put in some extra time and effort on consolidating your New Bottom Line. This is rather like what you might need to do if you had learned a language and then some time later had to visit the country concerned. Even if you had become quite fluent, it would still make good sense to revise what you knew, in order to meet the challenge successfully.

What to do if you need outside help

If the ideas in this book make good sense to you, but you have difficulty putting them into practice (perhaps because your Old Bottom Line is so strong or because it has had such a disabling effect on your life), then it may be helpful to look for a therapist who could help you to take things further than you can initially manage on your own. If you like this particular way of understanding low self-esteem and overcoming it, then your best bet is probably to look for a cognitive-behavioral therapist. If, on the other hand, you would prefer a more discursive, less structured approach, with a greater emphasis on developing insight than on practical techniques for achieving changes in daily living, then a counsellor or psychotherapist may suit you better. You will find some useful addresses at the end of this book.

As I said in Chapter 1 (pages 21–22), there is nothing shameful about seeking psychological help. It is not an admission of defeat, but rather a step towards taking control of your life and doing what needs to be done in order to become the person you would like to be. Supposing you were on a journey that involved travelling in the dark through unknown territory: you might well be glad of a guide, and be less likely if you had one to fall into swamps and lose your way than if you had ventured out alone. A therapist is like a guide. He or she will help you to acquire the map-reading skills you need in order to complete your journey successfully, and will teach you how to detect pitfalls and challenges and deal with them constructively on your own.

Similarly, if you were learning a new skill (for example, driving a truck or mastering a sport), it would probably seem reasonable to you to have some lessons or seek out a coach. Therapists are also like coaches. Their prime objective is to help you to develop your own skills to the point where the therapist becomes redundant, because now you can do it for yourself.

CHAPTER SUMMARY

- 1 The ideas and techniques you have learned as you worked through the book form a coherent program for change, each related to a particular aspect of the cognitive understanding of low self-esteem.
- 2 To ensure that you carry forward what you have learned and make it part of how you go about the business of living, it will be helpful to make a written Action Plan for the future.
- 3 The Action Plan should be straightforward and realistic. You should ensure that you are clear about how to measure your progress in carrying it out, and that it considers the impact of changes in you on those around you. It should also take account of limitations on your time and resources, and the timescale should be realistic.
- 4 In the Action Plan, summarize your understanding of how your low self-esteem developed and what kept it going. Note what you have learned as you worked your way through the book, and how you plan to build on new ideas and skills. Identify future events and stresses that might lead to a setback for you,

and work out what to do about it if one occurs.

Figure 42 Action Plan for the future: Briony

1 How did my low self-esteem develop?

When my parents died, I felt it was my fault. When my step-parents treated me so badly, that confirmed it. Finally, when my stepfather began to abuse me, I came to the conclusion that everything that had happened was a result of something in me. It all meant I was BAD. This was my Old Bottom Line. Once this idea was in place, other things happened that seemed to confirm it. For example, my first marriage was to a man who constantly criticized and ridiculed me. Because of what had happened earlier on, I thought this was just what I deserved.

2 What kept it going?

I kept on acting and thinking as if I really was a bad person. I never paid attention to good things about myself; I kept my true self hidden from people, because I was convinced that if they found out what I was really like, they would want nothing further to do with me. I was always very hard on myself. Anything I got wrong filled me with despair – yet more evidence of what a bad person I was. I could not have close relationships, except with the few people who persisted even when I held back. I allowed people to dismiss me and treat me badly. I didn't think I deserved anything better.

3 What have I learned on my way through the book?

To understand things better – it's my belief that I'm bad that's the problem, not the fact that I really am bad. I have learned that it is possible to change beliefs about yourself that have been around for a long time, if you work on them. I have learned to still my critical voice and focus on the good things about me. I am changing my rules and taking the risk of letting people see more of the true me.

4 What were my most important thoughts, rules and beliefs? What alternatives did I find to them?

I am bad → I am worthy

If I let anyone close to me, they will hurt and exploit me → If I let people close to me, I get the warmth and affection I need. Most people will treat me decently – and I can protect myself from those who don't.

I must never allow anyone to see my true self → Since my true self is worthy, I need not hide it. If some people don't like it, that's their problem.

5 How can I build on what I have learned?

Read the Summary Sheets for my new rules and Bottom Line daily – I need to drum them in. Keep acting as if they were true and observe the results. When I notice myself getting apprehensive and wanting to avoid things or protect myself, work out what I am predicting and check it out. Watch out for self-criticism – it's well entrenched and I need to keep fighting it. Keep on recording examples of good things about me – it's already made a difference. Make time for me – don't be afraid to remind the family when they go back to their old ways.

6 What might lead to a setback for me?

Getting depressed for any reason. Being consistently badly treated by someone. Something going very wrong for someone I cared about (I would tend to blame myself).

7 If I do have a setback, what will I do about it?

Try to notice the early warning signals, for a start. Ask my husband to help with this – he's sensitive to when I start hiding myself away and being irritable and defensive, and he notices when I start to be down on myself. Then get out my notes, especially the Summary Sheets and this Action Plan, and follow through on what I know works. Don't be hard on myself for taking a backwards step – it's bound to happen from time to time, given how long I have felt bad about myself and how I came to be that way. Be encouraging and kind to myself, get all the support I can, and go back to the basics.

Useful Books and Addresses

Useful books

- Alberti, Robert E. and Emmons, Michael L., *Your Perfect Right: A guide to assertive living*, San Luis Obispo, California: Impact Publishers, 1982
- Beck, Aaron T., *Love Is Never Enough*, New York: Penguin Books, 1989
- Burns, David D., *Feeling Good: The New Mood Therapy*, New York: Avon Books, 1980
- Burns, David D., *The Feeling Good Handbook*, New York: Plume/Penguin Books, 1990
- Butler, Gillian, *Overcoming Shyness and Social Anxiety*, London: Robinson, 1999
- Butler, Gillian and Hope, Tony, *Manage Your Mind: The Mental Fitness Guide*, Oxford: Oxford University Press, 1995
- Gilbert, Paul, *Overcoming Depression*, London: Robinson, 1997
- Glouberman, Dina, *Life Choices and Life Changes Through Imagework: The Art of Developing Personal Vision*, London: Unwin, 1989
- Greenberger, Dennis and Padesky, Christine A., *Mind over Mood: A Cognitive Therapy Treatment Manual for Clients*, New York: Guilford, 1995
- Lerner, Harriet G., *The Dance of Anger*, New York: Harper & Row, 1989
- McKay, Matthew and Fanning, Patrick, *Prisoners of Belief*, Oakland, California: New Harbinger Publications, 1991
- McKay, Matthew and Fanning, Patrick, *Self-Esteem*, Oakland, California: New Harbinger Publications, 1992 (2nd edition)
- Young, Jeffrey and Klosko, Jan, *Reinventing Your Life*, New York: Plume/Penguin Books, 1994

Useful addresses

Beck Institute of Cognitive Therapy and Research
1 Belmont Ave, Suite 700
Bala Cynwyd, PA 19004-1610
USA
Tel: 610 664 3020
Fax: 610 664 4437
Email: beckinst@grim.net
Website: www.beckinstitute.org

British Association for Behavioural and Cognitive Psychotherapies (BABCP)
Victoria Buildings
9-13 Silver Street
Bury BL9 0EU
UK
Tel: 0161 797 4484
Fax: 0161 797 2670

Email: babcp@babcp.com

Website: www.babcp.com

They have a list of cognitive behavioral therapists accredited by the organization.

British Association for Counselling and Psychotherapy

BACP House

15 St John's Business Park

Lutterworth LE17 4HB

UK

Fax: 01455 550243

Tel: 01455 883300

Email: enquiries@bacp.co.uk

Website: www.bacp.co.uk

British Psychological Society

St Andrews House

48 Princess Road East

Leicester LE1 7DR

UK

Tel: 0116 254 9568

Fax: 0116 227 1314

Email: enquiries@bps.org.uk

Website: www.bps.org.uk

They hold a directory of chartered clinical psychologists, the people most likely in this country to be trained in cognitive behavior therapy.

Center for Cognitive Therapy

PO BOX 5308

Huntington Beach, CA 92615-5308

USA

Tel: 714 963 0528

Fax: 714 963 0538

Email: mooney@padesky.com

Website: www.padesky.com

Center for Cognitive Therapy

499 N. Canon Drive, Suite 307

Beverly Hills, CA 90210

USA

Tel: 310 858 0240

Email: info@cognitivetherapyla.com

Website: www.cognitivetherapyla.com

Cognitive Therapy Center of New York

130 West 42nd Street

New York, NY, 10036, Suite 501
USA
Tel: 212 221 1818 (ext. 5)
Email: center@schematherapy.com
Website: www.schematherapy.com

International Association of Cognitive Psychotherapy
c/o William Lyddon
Department of Psychology, Box 5025
University of Southern Mississippi
Hattiesburg, MS 39406-5025
USA
Tel: 601 266.4602
Fax: 601 266.5580
Email: william.lyddon@usm.edu

MIND: The National Association for Mental Health
Granta House
15–19 Broadway
Stratford
London E15 4BQ
UK
Tel: 0181 519 2122
Fax: 020 8522 1725
Email: contact@mind.org.uk
Website: www.mind.org.uk

No Panic
93 Brands Farm Way Randlay
Telford TF3 2JQ
UK
Helpline: 0808 808 0545
Email: ceo@nopanic.org.uk
Website: www.nopanic.org.uk

Appendix

PREDICTIONS AND PRECAUTIONS RECORD SHEET

Date/Time	Situation What were you doing when you began to feel anxious?	Emotions and body sensations (e.g. anxious, panicky, tense, heart racing) Rate 0-100 for intensity	Anxious predictions What exactly was going through your mind when you began to feel anxious? (e.g. thoughts in words, images) Rate 0-100% for degree of belief	Precautions What did you do to stop your predictions coming true? (e.g. avoid the situation, safety-seeking behaviors)

PREDICTIONS AND PRECAUTIONS RECORD SHEET

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SPOTTING SELF-CRITICAL THOUGHTS			
Date/Time	Situation What were you doing when you began to feel bad about yourself?	Emotions and body sensations (e.g. sad, angry, guilty) Rate each 0-100 for intensity	Self-critical thoughts What exactly was going through your mind when you began to feel bad about yourself? (e.g. thoughts in words, images, meanings) Rate 0-100% for degree of belief
			Self-defeating behavior What did you do as a consequence of your self-critical thoughts

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[illegible]

DAILY ACTIVITY DIARY

	M	Tu	W	Th	F	Sat	Sun
6-7							
7-8							
8-9							
9-10							
10-11							
11-12							

M O R N I N G

DAILY ACTIVITY DIARY

A

F

T

E

R

N

O

O

N

12-1

1-2

2-3

3-4

4-5

M

Tu

W

Th

F

Sat

Sun

DAILY ACTIVITY DIARY

	M	Tu	W	Th	F	Sat	Sun
5-6							
6-7							
7-8							
8-9							
9-10							

E V E N I N G

E
V
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G

DAILY ACTIVITY DIARY						
	M	Tu	W	Th	F	Sat
10-11						
11-12						
12-1						

Review (What do you notice about your day? What worked for you? What did not work? What would you like to change?)

Mon:
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OVERCOMING MOOD SWINGS

A self-help guide using cognitive behavioral techniques

Jan Scott

ROBINSON
London

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Introduction by *Peter Cooper*

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Appendix

Introduction

Why Cognitive Behavior Therapy?

Over the past two or three decades, there has been something of a revolution in the field of psychological treatment. Freud and his followers had a major impact on the way in which psychological therapy was conceptualized, and psychoanalysis and psychodynamic psychotherapy dominated the field for the first half of the twentieth century. So, long-term treatments were offered which were designed to uncover the childhood roots of personal problems – offered, that is, to those who could afford it. There was some attempt by a few health service practitioners with a public conscience to modify this form of treatment (by, for example, offering short-term treatment or group therapy), but the demand for help was so great that this had little impact. Also, whilst numerous case histories can be found of people who are convinced that psychotherapy did help them, practitioners of this form of therapy showed remarkably little interest in demonstrating that what they were offering their patients was, in fact, helpful.

As a reaction to the exclusivity of psychodynamic therapies and the slender evidence for their usefulness, in the 1950s and 1960s a set of techniques was developed, broadly collectively termed ‘behavior therapy’. These techniques shared two basic features. First, they aimed to remove symptoms (such as anxiety) by dealing with those symptoms themselves, rather than their deep-seated underlying historical causes. Second, they were techniques, loosely related to what laboratory psychologists were finding out about the mechanisms of learning, which were formulated in testable terms. Indeed, practitioners of behavior therapy were committed to using techniques of proven value or, at worst, of a form which could potentially be put to the test. The area where these techniques proved of most value was in the treatment of anxiety disorders, especially specific phobias (such as fear of animals or of heights) and agoraphobia, both notoriously difficult to treat using conventional psychotherapies.

After an initial flush of enthusiasm, discontent with behavior therapy grew. There were a number of reasons for this, an important one of which was the fact that behavior therapy did not deal with the internal thoughts which were so obviously central to the distress that patients were experiencing. In this context, the fact that behavior therapy proved so inadequate when it came to the treatment of depression highlighted the need for major revision. In the late 1960s and early 1970s a treatment was developed specifically for depression called ‘cognitive therapy’. The pioneer in this enterprise was an American psychiatrist, Professor Aaron T. Beck, who developed a theory of depression which emphasized the importance of people’s depressed styles of thinking. He also specified a new form of therapy. It would not be

an exaggeration to say that Beck's work changed the nature of psychotherapy, not just for depressions but for a range of psychological problems.

In recent years the cognitive techniques introduced by Beck have been merged with the techniques developed earlier by the behavior therapists to produce a body of theory and practice which has come to be known as 'cognitive behavior therapy'. There are two reasons why this form of treatment has come to be so important within the field of psychotherapy. First, cognitive therapy for depression, as originally described by Beck and developed by his successors, has been subjected to the strictest scientific testing; and it has been found to be a highly successful treatment for a significant proportion of cases of depression. Not only has it proved to be as effective as the best alternative treatments (except in the most severe cases, where medication is required), but some studies suggest that people treated successfully with cognitive behavior therapy are less likely to experience a later recurrence of their depression than people treated successfully with other forms of therapy (such as antidepressant medication). Second, it has become clear that specific patterns of thinking are associated with a range of psychological problems and that treatments which deal with these styles of thinking are highly effective. So, specific cognitive behavioral treatments have been developed for anxiety disorders, like panic disorder, generalized anxiety disorder, specific phobias and social phobia, obsessive compulsive disorders, and hypochondriasis (health anxiety), as well as for other conditions such as compulsive gambling, alcohol and drug addiction, and eating disorders like bulimia nervosa and binge-eating disorder. Indeed, cognitive behavioral techniques have a wide application beyond the narrow categories of psychological disorders: they have been applied effectively, for example, to helping people with low self-esteem and those with marital difficulties. More recently these techniques have been used successfully by individuals with schizophrenia and manic depression.

At any one time almost 10 per cent of the general population is suffering from depression, and more than 10 per cent has one or other of the anxiety disorders. Many others have a range of psychological problems and personal difficulties. It is of the greatest importance that treatments of proven effectiveness are developed. However, even when the armoury of therapies is, as it were, full, there remains a very great problem – namely that the delivery of treatment is expensive and the resources are not going to be available evermore. Whilst this shortfall could be met by lots of people helping themselves, commonly the natural inclination to make oneself feel better in the present is to do precisely those things which perpetuate or even exacerbate one's problems. For example, the person with agoraphobia will stay at home to prevent the possibility of an anxiety attack; and the person with bulimia nervosa will avoid eating all potentially fattening foods. Whilst such strategies might resolve some immediate crisis, they leave the underlying problem intact and provide no real help in dealing with future difficulties.

So, there is a twin problem here: although effective treatments have been developed, they are not widely available; and when people try to help themselves they often make matters worse. In recent years the community of cognitive behavior therapists has responded to this situation. What they have done is to take the principles and techniques of specific cognitive behavior therapies for particular problems and represent them in self-help manuals. These manuals specify a systematic program of treatment which the individual sufferer is advised to work

through to overcome their difficulties. In this way, the cognitive behavioral therapeutic techniques of proven value are being made available on the widest possible basis.

Self-help manuals are never going to replace therapists. Many people will need individual treatment from a qualified therapist. It is also the case that, despite the widespread success of cognitive behavioral therapy, some people will not respond to it and will need one of the other treatments available. Nevertheless, although research on the use of cognitive behavioral self-help manuals is at an early stage, the work done to date indicates that for a very great many people such a manual will prove sufficient for them to overcome their problems without professional help.

Many people suffer silently and secretly for years. Sometimes appropriate help is not forthcoming despite their efforts to find it. Sometimes they feel too ashamed or guilty to reveal their problems to anyone. For many of these people the cognitive behavioral self-help manuals will provide a lifeline to recovery and a better future.

*Professor Peter Cooper
The University of Reading, 1997*

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I am grateful to the many people who have enlightened my thinking, supported my research or offered words of encouragement at different points in the last few decades. A few people deserve special mention. First and foremost, I was extremely fortunate at a very early stage of my career to meet with Professor Aaron T. Beck. More than anyone, he has changed the face of psychotherapy practice and research. The fact that we are even considering the use of cognitive therapy for individuals with bipolar disorders is down to his continued commitment to identifying the benefits of psychological therapies across the spectrum of mental disorders. His leadership and generosity have done much to unite cognitive therapists around the world and enabled them to collaborate and support each others' endeavours. Second, I am grateful to my clients who have helped me begin to understand the problems and potential ways to cope with bipolar disorders. I am grateful also for the funding made available to me for my research, particularly the Searle family. Last, but not least several individuals, particularly Jeni Bremner, Krystyna Green and Gillian Bromley, who have encouraged, cajoled and supported me whilst I changed jobs, moved house and (somewhere along the line) wrote this book. I thank them all for their kindness and their patience.

Jan Scott, March 2001

Preface

This book is aimed primarily at individuals who experience significant swings in their mood from the depths of depression to the highs of mania. As well as individuals with manic depression (also called bipolar disorder), this book may prove useful to those who suffer less severe, but nevertheless disruptive ups and downs in how they feel.

The book is divided into four parts, each of which starts with a set of aims. It is helpful to check these lists first, to be sure you understand what the overall aims are, and then to find out if some or all of each part of the book is of interest to you.

First, there are four questions to address:

1 Didn't I read that somewhere before?

I have *not* assumed that you will all start at page 1 and read the whole book in sequence. So, to make things easier for those who home in on certain sections, some parts of the book will overlap with earlier chapters. I hope I will be forgiven by those who systematically work their way through the text from start to finish. It's worth remembering, that a little repetition is often useful, as it will help information to stick in your mind.

The techniques I describe in this book to try to help you deal with your mood swings are drawn from cognitive behavior therapy. (More information about this approach is given in Chapter 5.) I have tried to describe each technique in sufficient detail for you to try it out on your own. However, this is not always simple, and you may not always understand what I am saying at first glance. If this happens, don't give up on the book straight away; it will help if you read through the description of the techniques a couple of times. Putting them into practice is bound to be easier if you are fairly clear about what you are trying to do and why.

2 Why all the notes and records?

Throughout this book I encourage you to write things down. I suggest making lists, recording thoughts, collecting information about what you did, evaluating your own activities and your responses to them, monitoring your moods, etc. Many individuals are reluctant to put things down on paper, and believe they can do many of these exercises in their head. I want to discourage you from this approach. I am not disputing your ability to remember information, but there are two important reasons for writing things down. The first is that you are often asked to do something with the information; for example, to change an activity, or challenge an unhelpful thought, and see what happens. In these cases it is useful to have a record of how the techniques applied to you and personal information on how you did things, so that if

you need to return to using this book in the future you aren't simply reliant on my descriptions; you can draw on your own experience. However, secondly and very importantly, writing it down makes it real. If you write down what you think, it is very powerful. You also gain a little distance from it, and will find working on it a lot easier. Also, many barriers or problems in achieving your goals are far more apparent when you make notes than if you just work through things in your mind. I really recommend you buy yourself a notebook to keep all the information together.

3 Aren't there more questions than answers here?

Two individuals using this book, even if they both suffer from manic depression, will differ in many other ways and may have quite different needs. The starting point for this book is that no two individuals are the same. To help understand your needs we have to apply an approach called 'guided discovery'. This means helping individuals discover things for themselves. This book sets out to guide you toward identifying the problems that concern you most and then to describe the techniques that other people have found useful in overcoming similar (but not necessarily the same) difficulties. This book is not about me trying to persuade you to accept my view, nor about offering information that is available in lots of other self-help books or textbooks on mood disorders.

To guide you toward understanding your mood swings and identifying problems to work on, I ask you hundreds of questions. Try not to be irritated by this; it is the only way to work out what the particular issues are for you. Most importantly, try not to turn the page if you see a list of questions on the horizon. The answers you give represent the critical first step in the process of overcoming your mood swings. You will also begin to learn the right questions to ask yourself to get to the root of any other problems you encounter in the future. Being clearer about problems puts you in a much better position to develop effective solutions.

4 How long does this go on for?

Working through the book from start to finish, repeating exercises and becoming confident in using the techniques described will probably take three to six months. However, if some of the approaches benefit you, you are looking at a lifelong commitment! At this stage, the most important thing is to take your time and go at a pace that suits you.

Part One of the book begins with important information about the nature of mood swings, the causes of manic depression, and the types of treatment available. It ends with a description of the cognitive behavioral model of mood disorders. The second part focuses on self-monitoring and self-regulation, including managing problems in accepting medication. The third part deals with the self-management of depression and hypomania. The fourth part looks at how you can monitor your mood swings in the future and how to apply your new skills to other aspects of your life.

Learning the techniques described in Part Two will help you in working on the issues described in Part Three. Likewise, the skills you have gained from Parts Two and Three can then be applied to the problems discussed in Part Four.

Try to be patient with yourself. Driving a car feels very unnatural when you are

first learning, but becomes second nature over time. In the same way, learning this new set of cognitive and behavioral techniques will not happen overnight, and there may be a few minor setbacks along the way. With practice, though, you will become increasingly confident that you can use the approaches described in this book and evaluate which work best for you. I hope that over time you will develop a set of skills that help you feel that you have as much control over your mood swings as possible, rather than feeling that they are in control of you.

PART ONE

Understanding Mood Swings

Aims of Part One

At the end of reading Part One of this book, I hope you will have:

- gained a greater understanding of mood swings and the different types of mood disorders;
- learned about the links between events, thoughts, feelings, and activities;
- developed an understanding of the vulnerability and stress factors that may increase the likelihood of experiencing an episode of a mood disorder;
- reviewed the acute and longer-term medications prescribed to individuals with mood disorders;
- learnt about the characteristics of effective psychological therapies offered to individuals with mood disorders;
- developed an understanding of the cognitive behavioral model of mood disorders, including the key role of underlying beliefs and automatic thoughts;
- noted the types of problems that may be targeted with techniques drawn from cognitive behavior therapy.

What Are Mood Swings?

We all experience different, sometimes intense, moods in reaction to day-to-day life events. However, some people experience extreme ups and downs that make it difficult for them to sustain a good quality of life. This book aims to help people identify and manage such mood swings and the problems associated with them. In order to achieve this goal, we need first to develop a shared understanding of moods, mood swings, and mood disorders.

Defining Mood States

Most dictionaries define “mood” as a “state of mind” or a “prevailing feeling or emotion”. Mood states are like the colours of the rainbow: each shade is distinct, but they blend into one another at the edges. Moving through the different shades of emotions is often a normal and appropriate response to the situations in which you find yourself. Although people are not always aware of their mood state, or sometimes struggle to find the word that best captures how they feel at any one moment, it is very rare to be devoid of any emotion.

Not only does your mood change in response to circumstances, your mood in turn influences the way you think and the way you behave. The phrase “seeing the world through rose-tinted glasses” clearly refers to the notion that when we are happy we see the positives and ignore the negatives in our environment. Likewise, many individuals who feel sad are totally focused on what is wrong with their world, finding it impossible to recall the good things in their life or shift their attention away from the negative things in their environment. This often leads them to avoid the very people or activities that may help change their mood. In ways such as these, moods play a significant role in how we live our lives. The important factors that influence mood and the way mood influences our actions can be demonstrated through imagining yourself in the following two situations.

Who Goes There?

You are lying in bed at night and you hear a noise downstairs.

Try to identify how you might feel if this situation arose, in a single word if you can (this is the best way to try to describe a mood). Now try to answer the following

questions:

- What's going through your mind?
- How would you react in this situation?

Many of you may have felt *anxious*, thinking that there was an intruder in the house. Individuals often notice that anxiety can be associated with physical changes, such as a faster heart rate or trembling hands. Depending on the circumstances (e.g. whether you are alone in the house, or sharing it with others) and the degree of your anxiety, you will have reacted in any of a variety of ways (e.g. hidden under the blankets, or woken a flatmate and jointly gone to explore the situation). Now, let us assume that you went to explore the cause of the noise and found that it was your cat. How would you feel then? Rather less anxious, I hope; but this change in mood might be accompanied by amusement in some, or by feelings of irritation in others.

This example has demonstrated that mood states may be determined in part by life events. The next scenario tries to explore the sequence of events, and emotional and behavioral responses to them, in more detail.

Things Can Only Get Better!

You wake up one morning having slept badly and are immediately aware of a pain in your neck. You feel irritable. You spill coffee on your clean shirt and end up being late leaving the house for your appointment. You are too far behind schedule to use public transport, so you invest what seems like a small fortune in a taxi cab. You are feeling "out of sorts", but manage to arrive on time at a meeting where you are meant to be presenting a brief but important talk to a large gathering of people. Some of these people you know well and some you have never met before.

This scenario conjures up a lot of questions, so you may find it easier to scribble your responses on a sheet of paper. Try to answer as many of the following questions as you can:

- When you spilt the coffee, what went through your mind? Were the comments you made inside your head forgiving and supportive, or punitive and self-blaming?
- If you were kind to yourself, did your upset mood stay the same, or did it improve?
- If you were being self-critical, did your mood change? If so, how did it change?
- Likewise, did you chastize yourself for taking a taxi or congratulate yourself for your problem-solving skills?
- What does the term "out of sorts" mean to you? Were you sad, depressed, irritable, angry, etc?
- Can you rate the intensity of this emotion (where 0 = minimum possible and 100 = maximum intensity of feeling)?
- When you got to the meeting, were the people who know you aware that you are "out of sorts"? If so, what was it they noticed about you that was different? Were you doing anything that gave these individuals a clue as to your mood?
- Did your emotional state catch the attention of people who didn't know you? If so, what is it that they may have noticed?
- Did you write these answers down or did you just answer the questions in your

head?

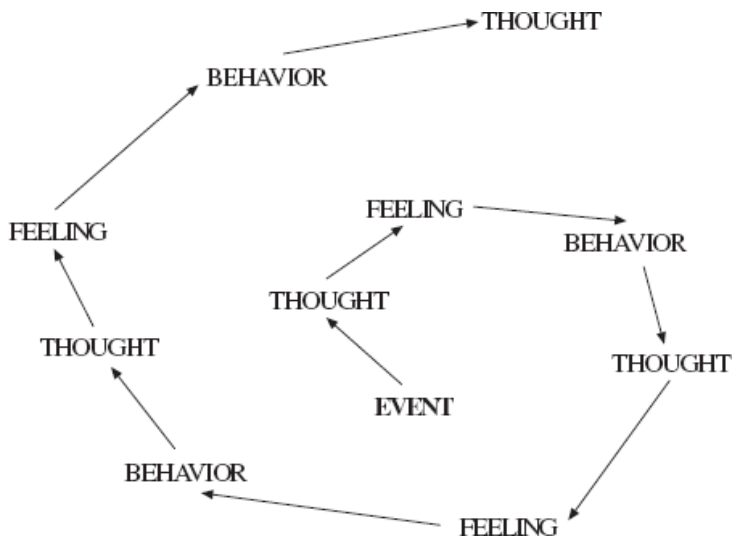
Different people will answer these questions in different ways. The clearest point of individual variation is when you identify what the phrase “out of sorts” means to you. For some, spilling the coffee will have led to a barrage of self-criticism (“I’m so clumsy”) and feelings of sadness (“I can’t do the simplest thing”). For others, the same event may have led to thoughts like “The world is conspiring against me,” or “It’s not fair.” Such thoughts are more often associated with feeling irritable or angry. At this stage, the most useful learning point is that it is helpful to *be as specific as you can be in describing your own emotions*. The reasons for this are simple but important: the more aware you are of how you feel, the easier it will be to understand how each mood state arises. Also, knowing what mood you are experiencing will largely dictate which strategies may be most helpful in changing uncomfortable or unhelpful feelings.

Did you think my last question about whether you wrote down your responses was unfair? (Be honest!) It was not meant to catch you out. The reason for including this question was to gauge how confident you feel about your ability to remember specific information, and how comfortable you feel with writing things down. Making notes was not vital to the success of that exercise. However, as we explore more complex issues in greater detail it may become harder to retain all the relevant facts in your head as well as working out how to use the techniques I will describe to help you change things. This is particularly true if you are trying to look at changes in your moods, thoughts and behavior over several days. For this reason you may wish to think about getting a notebook where you can record important information for your own use. We will come back to this issue later in the book, but we now need to explore the “*things can only get better*” scenario a little more.

The first thing to note is that, unlike the first example (a noise in the night), here it is not so clear what event has led to the sad or irritable mood state. A poor night’s sleep and a pain in the neck may have played a role; feeling anxious about giving a presentation may have been a factor. The pain and irritability or anxiety may have contributed to spilling the coffee. However, the most important aspect of that event is the thoughts you had about yourself in response to what happened, and how those thoughts influenced how you felt and how you behaved afterwards.

The next issue to consider is whether you were able to control your feelings and your behavior. For some of you, the intensity of the emotional reaction and the associated changes you experienced may have been too difficult to cope with, and your upset may have been obvious to others. Whatever pattern developed, we can use the information you gathered to establish a crucial sequence in the origins of mood swings, namely the *event–thought–feeling–behavior* link. Furthermore, as shown in Figure 1, the way you act in response to each mood will generate new thoughts that in turn will further affect your mood and behavior. In this way it is possible to enter a vicious cycle where moods, thoughts, and behavior become more and more negative. Or it is possible to enter a positive cycle, sometimes spiralling up and up to a point where you feel “high” and out of control.

Figure 1 The event–thought–feeling–behavior cycle



Defining Your Own Moods

You may have found the examples described rather difficult to relate to; so, before exploring mood swings in detail, it is important to apply the general model to your own real life experiences. To do this, try to pinpoint the last time you were “in a good mood” and the last time you were “in a bad mood”. Take each of these mood states separately, and for each one see if you can answer the following questions:

- 1 Can you describe the exact nature of the mood you experienced? (Try to find one word that captures how you felt, but also try to be more specific than just “good” or “bad”.)
- 2 Can you rate the intensity of each emotion (0 = lowest intensity possible, 100 = highest possible)?
- 3 Can you remember any events or situations associated with the onset of this mood (where you were, whether you were alone or with others, what you were doing at the time you became aware of the particular feeling)?
- 4 Can you identify any specific thoughts that you had at that time, or any themes that were going through your mind relating to how you viewed yourself, your world or your future?
- 5 Were there any other experiences (such as physical symptoms or biological changes) linked with this mood state?
- 6 What impact did the mood have on you and how you functioned?
- 7 Did anyone else notice or comment on any changes in you or your functioning?
- 8 How long did that mood state last overall (hours, days, weeks)?
- 9 Did anything particular occur that led to a change in your mood (making it either better or worse)?
- 10 Are the answers you have given typical or untypical of how things are when you are in this mood state?

The answers to questions 1–5 will demonstrate some elements in the “event–thought–feeling–behavior” chain. Don’t worry if there are gaps in your answers. Some people find it difficult at first to identify specific events or situations that precipitate mood shifts. Developing your awareness of these processes and being able to record them will take time and practice. Sometimes it still seems impossible to establish the links. This may be because in certain mood disorders (such as manic depression), mood changes may also result from internal changes in the body’s chemistry. Yet even where mood shifts are caused by chemical changes, some of the techniques described in this book to manage the symptoms of mood swings can still be very effective.

The answers to questions 6–10 give some indication as to whether your mood swings are so serious that they meet the profile of a “mood disorder”. The next chapter explores these issues in more detail.

Summary

- *Mood* is the term we use to describe feelings or emotions.
- There are links between what happens to us, how we view what happens to us, how we feel and how we behave:

event–thought–feeling–behavior

- How you behave or react to a situation will influence further your thoughts and feelings.
- Sometimes this process leads a person into a downward spiral, where they become more and more depressed.
- Alternatively, this may lead into an upward spiral, with a person becoming more and more elated.
- Mood, thoughts and behavior can affect physical or biological processes in the body.
- Mood swings can have a negative impact on a person’s quality of life.

When Do Mood Swings Become a Problem?

Mood swings that are particularly problematic usually share some or all of a range of characteristics. They are often:

- *unpredictable*, frequently fluctuating but without obvious precipitants;
- *uncontrollable*, emotional responses that seem inappropriate reactions to events and are beyond your control;
- *extreme*, with moods always experienced as intense highs or lows;
- *excessive*, with very frequent ups and downs occurring over many years;
- *extensive*, marked changes of mood that last a long time;
- *accompanied by associated changes*, in your thoughts, the way you behave, and possibly in the biological systems that impact on day-to-day functioning;
- *disruptive to lives*, causing significant problems for the individual experiencing them and/or for others.

Different Types of Mood Disorder

If your mood swings have most of these characteristics it is possible that you have a *mood disorder*. The major difference between mood disorders and other forms of mood swings is that mood disorders tend to show a consistent pattern of symptoms that occur together whenever a significant mood disturbance occurs (this collection of symptoms is referred to as a *syndrome*). Also, the changes persist for prolonged periods of time. The most common mood disorders are:

- dysthymia (chronic minor depression);
- major depressive disorder;
- manic-depressive disorder (also called bipolar disorders).

To understand the differences between these disorders, we need to look at the nature and degree of the mood changes and the associated features of each problem. As shown in Figure 2, *dysthymia* and *major depressive disorder* are characterized by a depressed mood with no “highs”. These are referred to as *unipolar disorders*. The typical pattern in major depression is periods of depression interspersed with periods of normal mood. Dysthymia has less severe symptoms than major depression, but there are relatively few periods of normal mood. Furthermore, feelings of sadness are very persistent, occurring virtually every day for two or more years. Not surprisingly,

individuals with dysthymia frequently report a lack of self-confidence and low self-esteem.

The term *manic depression* (or *bipolar disorder*) encompasses a number of syndromes characterized by both downswings and upswings. Individuals with *bipolar I disorder* experience episodes of major depression and mania. There are two different types of mania: *euphoric mania* (where the person is elated and full of optimism) and *dysphoric mania* (where the person is high but also irritable, impatient, and agitated). Less common forms of bipolar I disorder also exist, such as *rapid cycling* (where a person experiences four or more episodes of mania or depression within 12 months), or *mixed states* (where a person experiences the symptoms of mania and depression simultaneously).

Bipolar II disorder (where an individual experiences major depressions and less intense “highs” called *hypomania*) and *cyclothymia* (an unstable mood state, with milder ups and downs than those of bipolar I or II disorder) are together known as the *bipolar spectrum disorders*. Although these are less severe than bipolar I disorder, individuals with bipolar spectrum disorders still have to cope with significant difficulties in their daily lives. Hypomania tends to have more of the positive and few of the negative features of mania, but individuals with bipolar II disorder still experience severe and debilitating depressive episodes. Likewise, cyclothymia is characterized by less intense emotional shifts, but mood changes occur in an unpredictable way over many years, disrupting the lives of individuals and their families.

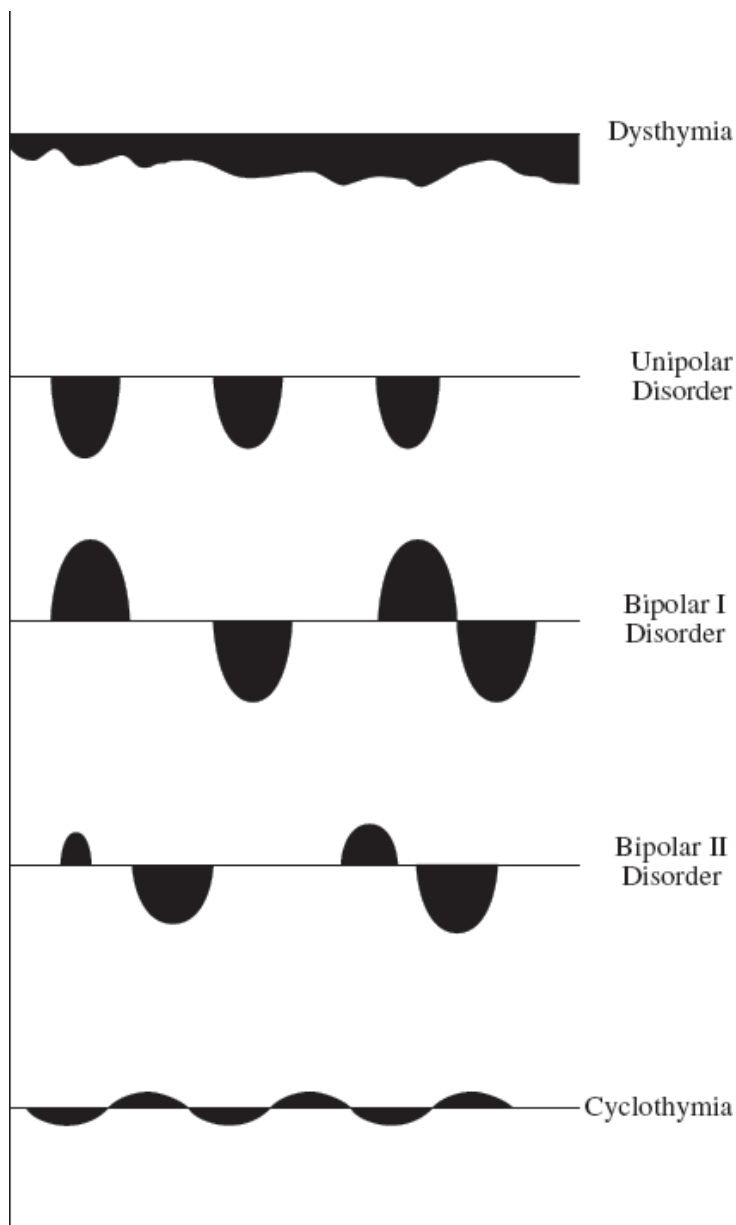


Figure 2 Patterns of mood change in mood disorders

Table 1 identifies some of the typical features of the depressive and manic phases of bipolar I disorder. You may find it useful to compare the descriptions of these states with the list you made relating to your own “good” and “bad” moods in Chapter 1. This will give you some indication as to whether your symptoms are the

same as those seen in the most common mood disorders. However, it is important to note that the list you have drawn up is unlikely to be identical to the information provided as I have outlined in the table only the commonest features of mania and depression. To be classified as bipolar I disorder, the symptoms have to be present for at least seven days for mania and at least 14 days for major depression. In reality, the symptoms usually persist for considerably longer. In bipolar spectrum disorders, many of these symptoms occur in a less severe form and for shorter periods of time.

If you are not sure about the nature of your problems, or wish to explore these issues in more detail, it may be useful to look at some of the references provided at the end of this book (p. 209–11). Alternatively, you may wish to seek advice from other relevant organizations or professionals. Some contact points are suggested in the section of “Useful Addresses” (p. 213–16).

Psychosis: The Most Severe Episodes

In very severe episodes of depression or mania, a person may lose touch with reality and develop psychotic symptoms. These may include experiencing unusual sensations (called hallucinations) such as hearing voices when no one is around or seeing things that no one else can see. Alternatively, the individual may develop abnormal beliefs about themselves or their world (termed delusions). The content of the delusions is usually influenced by the individual’s mood state. In mania, people frequently believe that they are special and have the power to change the world (e.g. believing that they have special skills as a negotiator and should fly to New York to negotiate world peace). In depression, people have a very negative outlook, often holding the conviction that they are evil and responsible for many of the injustices in society. Psychotic symptoms usually subside as the individual’s mood returns to normal. Although relatively rare, these symptoms can cause great concern, especially if the person is unable to recognize or accept that their abnormal beliefs are a product of their mental state and not a reflection of reality. In such extreme situations, treatment in an inpatient setting is frequently recommended.

Table 1 Characteristic symptoms of depression and mania

	Depression	Mania
To diagnose, must have:	Depressed mood, or loss of interest or pleasure in things you used to enjoy This must last at least 14 days. This change should be accompanied by 5 of the following symptoms:	Distinctly abnormal and persistently elevated, expansive or irritable mood. This must last at least 7 days. This change should be accompanied by 3 of the following symptoms:
Accompanied by:	<ul style="list-style-type: none"> • reduced interest, fatigue, or agitation; • insomnia or increased sleep (hypersomnia); • significant weight loss or gain; • reduced or increased appetite; • reduced ability to think or concentrate, or indecisiveness; • feelings of worthlessness; • recurrent thoughts of death. 	<ul style="list-style-type: none"> • increase in goal-directed activity; • excessive investment in pleasurable activities; • reduced need for sleep; • more talkative than usual with a pressure to keep talking; • subjective experience of thoughts racing; • increased self-esteem; • grandiose ideas.
Also:	These symptoms cause significant distress and/or impair social, occupational, or other important areas of functioning.	These symptoms should substantially impair functioning or require that the person is hospitalized.

Treating Manic Depression

The next two chapters explore the causes of manic depression and current approaches to treatment. Some of the information in these chapters may be of interest to people with unipolar disorders, but other texts published in this series, such as *Overcoming Depression* by Paul Gilbert and *Overcoming Low Self-Esteem* by Melanie Fennell may be more useful. Details of these books are given on p. 210.

Summary

- Mood disorders are characterized by
 - persistent mood disturbance, accompanied by
 - a consistent pattern of change in a person's thinking, behavior and physical functioning.
- The most common disorders associated with mood swings are:
 - recurrent unipolar depression;
 - bipolar I disorder;
 - bipolar II disorder;

– cyclothymia.

- Bipolar disorders are also referred to as *manic depression*.
- All of these disorders can cause severe disruption to a person's day-to-day life.

Who is at Risk of Manic Depression?

This chapter first looks at who is at risk of developing the most common forms of manic depression. It then explores the factors that may cause the onset of bipolar disorders or that increase the likelihood of relapse.

The Who and When of Manic Depression

Bipolar disorders affect about 1–2 per cent of the general population. About 0.5–1 per cent have bipolar I disorder. The exact number of individuals with bipolar spectrum disorders (bipolar II disorder and cyclothymia) is more difficult to determine as these problems may go unrecognized for many years. Unlike unipolar disorders, which affect more women than men, manic depressive disorders affect men and women approximately equally. Likewise, mood swings do not respect status: individuals from all walks of life and social backgrounds are equally likely to be affected.

Recent research suggests that mood swings often begin in adolescence and that the average age of onset of manic depression is the early 20s. Most people experience their first episode of manic depression between the ages of 20 and 40. Earlier age of onset is more common in individuals with a family history of manic depression. Onset after the age of 40 does occur, but is less common, and it is always important to ensure that later development of symptoms is not associated with an underlying medical condition.

Duration and Recurrence

By definition, mood disorders are recurrent disorders. Most individuals experience an episode of depression before they experience their first episode of mania or hypomania. Indeed, vulnerability to the latter may come to light because the medication used to treat depression sometimes sparks off an episode of hypomania. Recovery from the acute symptoms of mania usually takes one to three months, while full recovery from the acute symptoms of depression may take about six months. These estimates are very approximate; individuals vary enormously in how soon the most intense symptoms begin to settle, and how long it takes for them to become symptom-free.

Nineteen out of 20 individuals who experience an episode of mania will

experience at least one further episode of mood disorder at some point in their life. This often occurs sooner rather than later; there is a 50–50 risk of a further episode of mood disorder in the year after recovery from the last episode. On average, people with manic depression experience about four episodes during the ten years following the onset of the disorder. A past history of frequent episodes tends to predict a similar pattern for the future.

The Why of Manic Depression: The Causes

For many years, researchers emphasized the role of biological factors such as genes and brain biochemistry in causing manic depression. With the passage of time, it has become apparent that no single theory effectively explains why some individuals develop manic depression and others do not. Increasingly, researchers have emphasized how a number of interconnected biological, psychological, and social factors may play a role in the onset of manic depression.

The most coherent explanation of the development of manic depression is called the *stress vulnerability model*. This suggests, first, that some people have a particular vulnerability to developing a mood disorder; and second, that the onset of the disorder in an “at risk” individual is likely to occur when they are faced by increased environmental, emotional, or physical stress factors – what we call “stressors”. This section will describe the most well-recognized vulnerability factors and then explore some of the factors that may trigger the onset or recurrence of intense mood swings.

Vulnerability Factors

Vulnerability to develop manic depression is probably inborn or laid down at a very early stage in an individual’s life. The most important elements in vulnerability all relate to biological factors: genetics, disturbances in brain biochemistry, and disrupted circadian rhythms. Future research (such as that undertaken by the Human Genome Project) may eventually show links between these three areas. For example, genes are likely to influence brain biochemistry or circadian rhythms. At the other end of the spectrum, the role of psychological factors is considered. Personality characteristics are probably *not* a risk factor for developing manic depression, but they may influence the age at which the first episode occurs or the frequency of relapse.

Genetic factors It has long been suspected that genes play a part in vulnerability to manic depression. The increased likelihood that the children, sisters and brothers of a person with manic depression will also develop a unipolar or bipolar disorder clearly indicates that mood disorders may be inherited. If one parent has bipolar disorder, there is a one in seven chance that their child will develop bipolar disorder. If both parents have a bipolar disorder, the risk increases to somewhere between one in two and one in three. This suggests that the more genes a person shares in common with an individual or individuals with bipolar disorder, the more likely it is that they too will develop the disorder. This has been confirmed by research on twins who have a family history of bipolar disorder. If one member of a pair of twins has a bipolar disorder, the likelihood that the other twin will develop manic depression is much greater in identical twins (who share all their genes in common) than in non-identical

twins (who have half their genes in common).

Research to date suggests that a number of different genes, rather than one single gene, may be important in increasing the likelihood that an individual may develop a mood disorder. However, not everyone with a family history of manic depression goes on to develop that disorder. This suggests that people inherit only the *risk* of developing a mood disorder; they do not inherit the disorder itself. This may sound unnecessarily complicated, but a simple analogy may help to make the difference clear. Consider what happens if you dissolve some salt in a pan of water. If you then put the pan over a source of heat, the salt (vulnerability factor) lowers the temperature at which the water boils (disorder develops). However, the possibility (risk) that the water will boil at a lower temperature is not apparent simply from looking at the water in the pan. It is only obvious when heat (a stress factor) is applied.

Brain chemistry The brain comprises many millions of nerve cells with a vast number of interconnections. Information is carried between these cells by chemicals called neurotransmitters. The chemicals pass from one nerve cell to receptors (a kind of docking station) on adjacent nerve cells. There are a large number of neurotransmitters in the brain, but three of them – noradrenalin (also known as norepinephrine), serotonin, and dopamine – have repeatedly been shown to be abnormal in individuals with mood disorders. These three neurotransmitters are collectively known as monoamines. Some studies have reported abnormalities in the levels of monoamines in the brain; other research has suggested that there are changes in how the nerve cell receptors respond to these neurotransmitters.

The monoamines are known to be active in those parts of the brain that influence our emotions, thinking, and the way we behave, but it is difficult to establish the exact role in mood disorders played by imbalances in neurotransmitters. Brain chemistry certainly affects behavior; but we also know that behavior (which can in turn be affected by thinking and emotions) may affect brain chemistry. So it is not clear whether the observed abnormalities in monoamines cause an episode of mood disorder, or arise as a consequence of an episode.

To be certain that imbalances in neurotransmitter levels play a role in mood disorder, we need to know how this effect is produced. Current theories suggest that monoamine abnormalities increase the likelihood of a more extreme reaction to physical or emotional stressors, and that the imbalance also delays the return of the nervous system (and therefore the individual) to the previous state of equilibrium.

Circadian rhythms The term “circadian” derives from Latin, and means about (*circa*) one day (*diem*). Many processes in the body are carefully regulated by the rhythmic release of certain chemicals and hormones. The most obvious example of this is the sleep–wake cycle, although blood pressure, body temperature, and many other biological functions also change in a precise and regular pattern over the course of a day. Genetic factors may play a role in setting each individual’s internal biological clock. However, environmental factors, particularly the number of daylight hours, and social factors, such as a regular lifestyle (e.g. regular meal times, social activities, etc.), also significantly influence an individual’s circadian rhythms.

Disruptions in circadian rhythms can be associated with mood disorders. For example, mania is more common in the summer months in the northern hemisphere

(when exposure to daylight is longer). Episodes of mood disorders may also occur following long-haul airline flights that can disrupt the sleep-wake cycle. These findings have led many researchers to propose that abnormalities in an individual's "biological clock" may play a role in the development of mood disorders. It has also led to speculation about the types of stressors that are most likely to disrupt circadian rhythms and may precipitate episodes of mood disorder. Finally, proposals have been put forward about how to reduce the risk of circadian rhythm disruption by developing more stable patterns of daily living (see "self-regulation" p. 97).

Psychological vulnerability factors This term encompasses many aspects of personality, including the different ways we think, feel, behave, and cope. I use this concept, rather than just referring to an individual's 'personality', as the use of blanket terms such as "neurotic" or "personality disorder" has done little to help us unravel the role of individual psychology in the development of mood disorders. Also, few people fit neatly into the rather arbitrary personality categories described in textbooks.

Personality can be thought of as the sum total of an individual's actions and reactions. Some aspects of personality may be inherited, but much of who we become is shaped by our early environment and childhood learning experiences. There is evidence linking the development of unipolar disorders with adverse early circumstances, but this is not the case for bipolar disorders. Nor is a person with a particular personality "type" any more likely to develop manic depression than any other individual. Most importantly, there is no evidence of any personal inadequacies in individuals who develop mood disorders.

If no overall personality profile makes individuals vulnerable to bipolar disorders, do any individual characteristics specifically increase the risk of developing bipolar disorders? Again, the answer is no. There is a small body of evidence suggesting that how people respond to stressors, and what coping strategies they employ, may have a bearing on the age at which at risk individuals experience their first episode of mood disorder.

How a person acts and reacts, and what coping style they adopt, *do* play a role in increasing or decreasing the likelihood of relapses. For example, it seems that relationship problems cause more stress to a person who has a strong belief that he will not be able to cope unless he has someone he can rely on. This stress may lead him into a downward spiral. Similarly, an individual with manic depression who believes that she should control her own destiny finds situations that undermine her prospects for self-determination particularly stressful. These examples suggest that the importance of a particular life event differs between individuals depending on the underlying beliefs they have about themselves, their world, and their future. These beliefs will influence how individuals think and feel about a situation, how they respond, and what coping strategies they employ.

On a positive note, it is also true that certain coping styles can protect a person against a further episode of mood disorder. For example, a person with well-developed problem-solving skills may be able to take the sting out of many potentially stressful experiences and prevent a vicious downward spiral into depression. Most importantly, as discussed later in this book, it is possible for you to modify how you act and react in situations that are particularly stressful to you.

Stress Factors

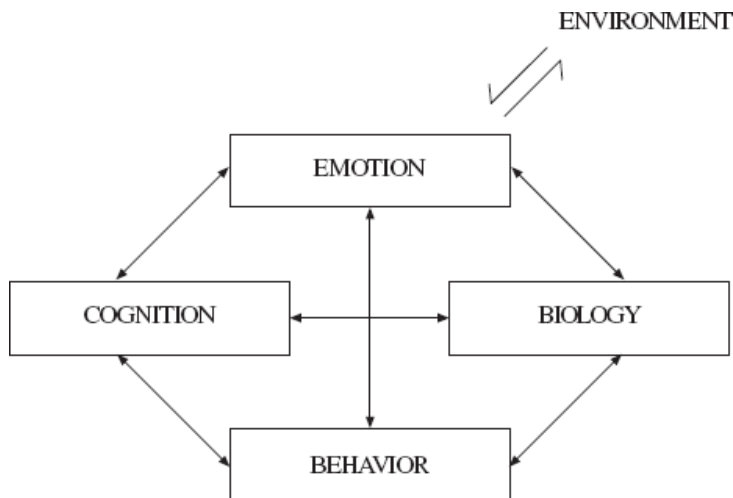
Stress–vulnerability models emphasize that biological factors such as genes may play a part in increasing an individual’s risk of developing a bipolar disorder, but that events or experiences will affect whether that vulnerability becomes apparent. The factors described below may be associated with either the onset or the recurrence of manic depression.

Physical factors In individuals with a vulnerability to developing manic depression, there are a number of physical stressors that may precipitate an episode of mood disorder. Disorders of the endocrine glands, such as an overactive thyroid, may disrupt circadian rhythms and led to depression or to mania. Alcohol may act as a physical stressor, disrupting sleep and other circadian rhythms, and possibly causing monoamine imbalances. Similar reactions occur in response to excessive use of stimulants, such as illicit drugs or caffeine. Other medical disorders, and some of the medications used in treatment (e.g. steroids), can also precipitate mood changes and the associated symptoms of manic depression.

Life events There is a well-documented association between the occurrence of life events such as the loss of a significant person and the onset of depression. Research also shows that individuals who experience other types of interpersonal life events, such as the break-up of a relationship, or other types of loss events, such as being made redundant, may also develop depression. In contrast, people who are perfectionists may not be affected so obviously by one major life event, but may find more minor but frequent life events (“hassles”) particularly stressful.

As noted in the discussion of psychological vulnerability factors, life events associated with the onset of a mood disorder often have a special meaning for that individual. This more intense response may be associated with changes in brain chemistry or circadian rhythms. These changes in turn disrupt the physical state of that individual more than someone who is not at risk of developing a mood disorder. These disruptions may also be more prolonged, further affecting the individual’s cognitions (beliefs, thoughts, and images), feelings, and behaviors. This interaction between the four aspects of the individual (biology, behavior, emotions, cognitions) and their environment was first described by Padesky and Mooney in the USA. It is illustrated in Figure 3.

Figure 3 The five-system model: links between an individual’s cognitive, biological, emotional, and behavioral functioning and the environment



It is often easier to explain the links between negative life events and depression than to understand how life events are associated with an episode of mania. Recent research from Pittsburgh in the USA suggests that events that particularly disrupt a person's day-to-day patterns of activity and their sleep-wake cycle may trigger the onset of mania. Examples are acute sleep disruption brought about by having to go out of the house unexpectedly in the middle of the night, or the substantial disruptions of daily routine caused by starting a full-time college course. The researchers found that these "social rhythm disrupting" (SRD) events occurred more frequently in the eight weeks prior to the onset of a manic episode than in the eight weeks prior to the onset of a depressive episode. It is suggested that SRD events lead to changes in the individuals' circadian rhythms, in turn causing the observed disturbances in physical, cognitive, emotional, and behavioral functioning.

Social factors No one lives in a vacuum; everyone's environment and quality of life will influence their state of well-being. An individual's social circumstances may increase or reduce the risk of experiencing more extreme mood swings. A key constituent of a person's environment is their relationships with other people. As noted earlier, interpersonal problems may be associated with the onset of an episode of mood disorder in a vulnerable individual. There is evidence that living in an environment where people have a negative style of interacting and are overly critical of each other may increase the risk of a vulnerable individual experiencing a mood swing. Conversely, the positive support and encouragement received from family or friends can buffer a person against the vicissitudes of daily life. A close, confiding relationship may actually help prevent a person at risk of mood disorder from experiencing more extreme mood swings. Such support also seems to reduce the risk of depressive episodes becoming persistent.

Sometimes the same vicious "event-thought-feeling-behavior" cycles that may tip one individual into a mood disorder can influence interactions between individuals. The reactions of other individuals to the way someone with a mood disorder acts will be determined by their interpretations of that person's behaviors. These interpretations in turn influence the observers' own emotional and behavioral

responses. In this way the symptoms of mood disorder can be a source of stress and distress for all individuals in the immediate environment.

Interestingly, many relatives of people with mood disorders comment that hypomania or less intense “highs” can be more distressing to cope with than mania. This may be because it is easier to accept that someone who is manic is out of control and unable to stop themselves from behaving inappropriately, whereas family members are often unsure that an individual with hypomania is unwell, and may interpret that person’s actions or behaviors as selfish or unkind. This highlights how important it is for everyone involved in a social network to understand the nature of mood disorders and the typical symptoms that a person experiences. Such an understanding can go some way to reducing misunderstandings and tensions.

Living with someone who has a history of intense mood swings may bring long-term problems in relationships, ranging from repeated struggles to forgive indiscreet or ill-judged actions during manic episodes, to being overprotective and trying to wrap a person in cotton wool in the hope that this will prevent their ever experiencing another mood swing. Again, strains of these kinds in a relationship may have an adverse effect on both parties, and it is important to try to identify and change negative patterns of interaction to improve each person’s sense of well-being.

Summary

- Bipolar disorders affect 1–2 per cent of the population.
- Men and women are affected equally.
- The first episode of manic depression usually occurs between the ages of 20 and 40 years. Earlier age of onset is more common in people with a family history of mood disorder.
- On average, a person with manic depression will experience about four episodes of disorder over the first ten years.
- The stress–vulnerability model offers the best explanation of how bipolar disorders develop.
- Vulnerability factors increase the risk that someone may develop manic depression but they do not *cause* the disorder.
- Vulnerability factors can be classified as biological and psychological.
 - Key biological factors include genetic inheritance, neurotransmitter abnormalities, and circadian rhythm disruption.
 - Psychological factors affect the likelihood of having further episodes of manic depression. An individual’s underlying beliefs and their coping style will affect what events they find stressful and how they act and react.
- Stress factors may expose an individual’s underlying vulnerability to developing an episode of mood disorder.
- Stress factors can be classified as physical factors, life events, and social factors.
 - Physical factors include medical disorders but also the excessive use of alcohol or stimulants.
 - Life events include experiences with a specific personal meaning for the individual and SRD (social rhythm disrupting) events.
 - Social factors include the individual’s social situation and interpersonal relationships.

Current Approaches to Treatment and Management

For many decades, research on manic depression focused on biological factors that might cause the disorder and on physical interventions – that is, medications – that might reduce the symptoms. Little attention was paid to the role of psychosocial therapies in modifying the factors that might precipitate an episode of manic depression, or in helping individuals to overcome the adverse psychological or social consequences of such an episode. Largely because of the efforts of individuals with mood disorders and their families, this situation is beginning to change.

This chapter offers an overview of the aims of treatment, and the roles of physical and psychological therapies. The “no treatment” option and complementary (“alternative”) therapies are also briefly discussed.

The Aims of Treatment

The primary aims of treatment for an individual with a bipolar disorder are to:

- reduce the acute symptoms and problems associated with depression or mania;
- restore an individual to their prior level of functioning;
- prevent any recurrence of mania and depression, or reduce the severity of episodes that do occur.

Individuals with a bipolar disorder will know only too well that these aims are simple to record but sometimes very difficult to achieve in practice. Also, these represent the bare minimum individuals will want from treatment. There are many other potential issues to address. For example, we may wish to go beyond returning an individual to their previous level of functioning, and take their day-to-day living and coping skills to a higher level. Many individuals wish not only to overcome the difficulties associated with mood disorders, but also to improve their overall sense of health and well-being.

Medication can help to achieve some of the aims of treatment, but it cannot resolve all the issues identified. Likewise, reliance on psychological therapy alone is rarely advisable. It seems that no single treatment can help an individual overcome all the symptoms and problems experienced, and that a combined approach offers the best

management strategy. The degree of emphasis on medication or psychosocial approaches will vary from person to person, and also according to the severity or phase of the mood disorder. Most individuals with manic depression benefit from taking medication at some stage, if only because it helps them become sufficiently settled to allow them to engage with and concentrate on any psychological interventions being offered.

The degree of psychological support required by individuals varies enormously. Some find that informal support from people in their social network or membership of a voluntary organization enables them to cope with their problems. Other individuals benefit from a more intensive approach, such as a course of cognitive behavior therapy, a framework that is explored in more detail in the next chapter.

A Brief Review of Physical Treatments

The term “physical treatments” refers mainly to the use of medication, although it also includes other techniques such as electro-convulsive therapy (ECT). Many individuals regard these as dubious options. However, to enable you to make an informed judgment about whether you will accept medication or not, it is important to describe the rationale for these treatments, to establish the facts and dispel the myths.

Treatment is usually considered in two stages: the acute treatment phase, when the aim is to reduce the intensity of current symptoms; and the longer-term phase, when the aim is to prevent recurrent episodes of mood swings.

Acute Treatments

Medication for Hypomania and Mania The treatment of hypomania and mania is similar. The main differences are that individuals with hypomania rather than mania may respond to lower doses of medication and are less likely to need to be admitted into hospital.

Mood-stabilizing drugs, such as lithium, carbamazepine, and valproate, are a key component of the treatment of mania or hypomania. As well as having longer-term benefits, all three also have anti-manic properties. Lithium is the most commonly prescribed anti-manic medication, with carbamazepine or valproate being used more frequently in individuals who have not responded to lithium. Certain symptom patterns, such as rapid cycling disorder or mixed states (noted in Chapter 2 above), also appear to respond better to carbamazepine or valproate rather than lithium alone. The main problem encountered in treating mania with mood stabilizers is that the drugs can take seven to ten days to begin to have a significant effect. Given that mania is an emotionally distressing and potentially physically exhausting state, it is usual to offer additional medications.

Anti-psychotic drugs, or alternatively benzodiazepines, are usually used in addition to a mood stabilizer during the first week or so of a manic episode in an attempt to reduce physical and mental agitation and to improve sleep. The advantage of these medications is that they work very rapidly (within two to four days). The anti-psychotic drugs are particularly useful when a person's thinking is very disorganized or they report delusions. However, the side-effects can be troublesome

and sometimes make a person feel more rather than less restless. Benzodiazepines are often used if an individual cannot tolerate anti-psychotic medications or is experiencing high levels of anxiety.

The anti-psychotic medications most commonly prescribed during a manic phase are haloperidol or one of the newer “atypical anti-psychotics”, such as risperidone, sulpiride, or clozapine. Benzodiazepines such as clonazepam or lorazepam can be prescribed as alternatives, but their use is limited to the minimum possible duration to avoid any problems with benzodiazepine dependence.

These additional drugs can usually be withdrawn once the mood stabilizer has begun to have a clear effect.

Medication for Depression

Anti-depressant medication may be used if an individual experiences an acute depressive episode. These drugs are rarely used alone in a person with bipolar disorder, as the anti-depressant effect may bring on an episode of hypomania. Although this is uncommon, it is advisable to monitor mood changes very carefully while anti-depressants are being taken. Most individuals who are prescribed an anti-depressant continue to take a mood stabilizer. The latter have weaker anti-depressant than anti-manic effects, but nevertheless for some people bring about a degree of improvement on their own. For someone who is feeling agitated or reports psychotic symptoms, mood stabilizers may be prescribed along with anti-psychotic medication.

Commonly used medications are tricyclic anti-depressants or TCAs (such as amitriptyline or imipramine), second-generation anti-depressants (such as lofepramine), selective serotonin re-uptake inhibitors or SSRIs (such as fluoxetine or sertraline), and noradrenalin re-uptake inhibitors (such as venlafaxine or nefazadone). All are equally effective, but they differ in the kinds of side-effects associated with them, so certain drugs will be more suitable than others for certain individuals. The anti-depressants called monoamine oxidase inhibitors or MAOIs (such as phenelzine) are less commonly prescribed for individuals with bipolar disorders because of their greater potential for inducing “highs” and their potentially dangerous interactions with other drugs and some foods. A trial of treatment with an MAOI may, however, be recommended if a person has failed to respond to the other classes of anti-depressants described.

Seven out of ten individuals with depression will respond to the first or second anti-depressant medication they are prescribed. It is thought that anti-depressants work by correcting imbalances in neurotransmitter levels or changing nerve-cell receptor activity. However, this effect is not immediate. It takes about two weeks for anti-depressants to begin to act, and usually about six weeks to judge whether the anti-depressant is truly effective for that individual.

Admission to Hospital

If a person experiences an episode of mania that is totally out of control and unresponsive to treatment, or a severe depression accompanied by psychotic symptoms or intense suicidal ideas, they will almost certainly need to be admitted to the hospital. Admission is sometimes helpful in other situations, too, for example enabling careful observation of an individual’s response to medication. It may also

ensure a person avoids actions or behaviors that are dangerous or that they may regret later. Research suggests that, after they return to a normal mood state, most individuals hospitalized with a severe episode of bipolar disorder are grateful that they were admitted, even though they may have been ambivalent about this option or even actively opposed it at the time.

Electro-Convulsive Therapy

A small proportion of those individuals admitted to hospital may be so unwell that they also need treatment with ECT. Very rarely, an individual is offered ECT because their acute symptoms have previously responded especially well to this approach.

Admission to hospital is often recommended if someone is going to receive ECT, as it allows careful monitoring of the response. A course of ECT usually comprises six to twelve treatments over a period of about three to four weeks. Eight out of ten people who receive ECT appear to benefit. More importantly, improvement in very severe disorders may be more rapid than can be achieved with medication alone.

How ECT actually works is unclear. One theory is that it improves the sensitivity of nerve-cell receptors to neurotransmitters, leading to stabilization of the brain activities that regulate emotions.

Longer-Term Treatment (Prophylaxis)

Individuals with a bipolar disorder will nearly always be offered a prescription for longer-term treatment with a mood stabilizer to reduce the severity or frequency of mood swings. The most commonly used mood stabilizers are those referred to above: lithium, carbamazepine, and valproate. Another drug, called lamotrigine, has also recently become available. Lithium is thought to reduce episodes of mood disorder through its action on receptors and chemicals found on the walls of nerve cells, which appears to regularize the activity of the areas of the brain that control emotions and behavior. Carbamazepine, valproate, and lamotrigine are anti-convulsants and were first introduced as treatments for epilepsy. However, they appear to act in a similar way to lithium and so are also effective as mood stabilizers.

About six out of ten individuals who take lithium for prophylaxis respond well, and for those who do not there is a good chance that one of the other mood stabilizers will help. Some people benefit from a combination of two mood stabilizers prescribed together. Individuals with a bipolar disorder who also have drug- or alcohol-related problems tend to respond less well to all of the mood stabilizers. All mood stabilizers can cause side-effects. Where lithium and carbamazepine are prescribed, regular blood tests must be taken to monitor whether the amount of medication being prescribed is likely to be effective, and also to ensure that the drugs are not having any adverse effects on the body.

Mood stabilizers need to be taken for about two years to determine if they have reduced the frequency or severity of mood swings. While research suggests that the benefits of mood stabilizers outweigh the disadvantages, many individuals struggle to keep taking them regularly as prescribed. Sometimes this is because of side-effects; other individuals simply fail to establish a regular routine for taking the tablets. However, it is equally common for individuals to report that they stop taking medication out of a desire to be in control of their own life, and because of the

negative thoughts they have about prophylactic medication. This problem is discussed further on p. 115–18).

The “No Treatment” Option

As we have just noted, many individuals stop taking medication because of their personal attitudes and beliefs. A dislike of taking medication may be compounded by some less than ideal interactions with health-care professionals, as a consequence of which some individuals decide to vote with their feet and do not attend any appointments offered. These attitudes and actions are not peculiar to individuals with mood disorders, and are just as likely to be seen in individuals receiving long-term treatment for medical disorders such as hypertension, asthma, and diabetes.

If you do have a history of mood disorder and feel that you wish to take the “no treatment” option, it is important to be sure that you are taking this decision in the cool light of day, and not in the middle of an upswing or a depressive episode. Research suggests that individuals who stop taking mood stabilizers often make this choice when they have been symptom-free for some time and come to doubt that the benefits of persevering with medication exceed the negative aspects. Unfortunately, there is considerable evidence that mood disorders are more likely to recur than not, and that recurrence is more rather than less likely without treatment. Nevertheless, experience and research have taught me that at least 50 per cent of individuals to whom mood stabilizers are prescribed will stop taking them at some point. So, if you have stopped your medication or cannot be dissuaded from taking this course of action, the following ideas may be helpful to you.

The first and most important is to view this treatment-free period as an experiment. This has many advantages, not least that it keeps the door open for a return to treatment without such a decision being viewed by you or anyone else as a personal failure. Also, try to identify (and ideally record) how and when you will know whether this “no treatment” experiment has been successful or not. How long will you try to go it alone? What are your criteria for success? Lastly, as this is an experiment, it will need to be evaluated; so it is helpful to keep a record of your progress, so that you can make an accurate assessment of the outcome.

Below is a list of points that some individuals who stopped their treatment report that they have found helpful. The more of these you are able to include in your plan, the better:

- Review your decision by making a list of the advantages and disadvantages of this choice.
- Carefully consider if there is anything that someone might do, that would change your mind; if so, go to talk to them.
- Talk to people who know you, and ask for their views on the advantages and disadvantages of what you propose.
- If you cannot talk to someone you know well, seek advice or support from a self-help organization for individuals with manic depression.
- Read about manic depression and try to assess how likely you are to experience a long symptom-free period, and what will protect you against relapse.
- If you are currently still taking medication but are definitely intending to stop, it is better to make this change very gradually. Research shows that suddenly stopping

mood stabilizers increases the likelihood that you will have a relapse within a few months.

- Avoid non-prescription drugs, excess consumption of alcohol, and caffeine or other stimulants.
- Try to regularize your day-to-day patterns of activity, and keep a record of your mood and any other symptoms you experience so that you can assess your progress.
- Try to identify someone you trust, with whom you would be prepared to speak regularly to review your mood state and how you are coping.
- Agree on a plan with that person about what you will do if the experiment is unsuccessful, things are going badly, or you experience a recurrence of symptoms. Best of all, write down the plan in detail and both keep a copy.

Finally, it may be appropriate to consider the pros and cons of seeking a course of psychological therapy. However, you should be aware that most therapists would prefer you to be taking prophylactic medication, as well, and will almost certainly at some point want to discuss your rejection of the other treatments available.

Complementary Therapies

Homoeopathic, Herbal, and Other Remedies

The appeal of complementary (alternative) therapies is easy to understand. These treatments are largely viewed as more natural and less noxious than the manufactured medications prescribed by doctors. However, it is not clear whether any homoeopathic or herbal remedies are of benefit in bipolar disorders. Treatment trials are currently under way to assess the anti-depressant effects of St John's Wort (*hypericum perforatum*), but these studies seem to be the exception rather than the rule. Also, there is evidence that St John's Wort may reduce absorption of iron and other minerals into the body, which may make it a less attractive option than it first appeared. At the present time, the case for the use of complementary treatments is neither proved nor disproved.

Many individuals report benefits from homoeopathic or health-store remedies, vitamin or dietary supplements, or other treatments. There is no simple way of assessing which, if any, of these may be of benefit to you. If you are tempted to try these substances, then it is probably helpful to consider the following precautions:

- Given the lack of evidence for their effectiveness, it is unwise to use these remedies *instead of* prescribed medications.
- If you are going to try any remedies, make sure you know exactly what is in the package, and check the dosage instructions carefully. There is no standardization across brands and the actual doses vary considerably between products.
- Before taking the remedy, seek reliable information and advice on any potential side-effects, adverse effects, or potential interactions with the medications you are being prescribed.
- Always tell the person prescribing your medication what other remedies you are trying out.
- As the exact benefits or adverse effects of these substances may not be certain, it is

better to avoid trying them out when you are experiencing acute symptoms or severe mood swings, or are under stress.

In summary, the byword is caution. You may find a remedy that helps you relax or has other positive effects, but the fact that these remedies can be purchased over the counter does not guarantee either that they have benefits or that they produce no side-effects.

Relaxation Therapies

Relaxation therapy, aromatherapy, massage, and meditation can all help people to relax. There is no evidence that these approaches are effective alternatives to standard treatments in individuals with bipolar disorders. However, given the importance in treating mood disorders of reducing stress and improving well-being, these may be helpful additional strategies, particularly if you are not keen on exercise regimes.

Psychological Therapies

Most individuals with a bipolar disorder, and their families, need an opportunity to talk about the impact of the disorder on their lives and to get help in coming to terms with the problems it brings. These may include coping with stigma, low self-esteem, the loss of friends or employment, tensions within relationships, dealing with the symptoms of the disorder or with drug and alcohol misuse, or trying to make realistic plans for the future. Some individuals find that once their acute symptoms have settled, or medication has reduced the intensity of their mood swings, they are able to use their own problem-solving skills and start to cope on their own with the challenges ahead. Others are able to work through these issues by talking with people from their social network, or through contact with other individuals involved in self-help or similar organizations. Mental health professionals can also offer education and support to help an individual to adjust to what has happened to them. However, many individuals welcome the opportunity to participate in a more formal course of psychological treatment.

To date, only a handful of scientific studies of the use of psychological therapies in bipolar disorders have been completed, though large-scale projects are now under way on both sides of the Atlantic. As a consequence, hard evidence on their effectiveness is relatively limited; but the information available so far suggests that behavioral family therapy (BFT), interpersonal social rhythm therapy (IPSRT), and cognitive behavior therapy (CBT) can be used successfully in both unipolar and bipolar disorders. Both IPSRT and CBT can be used with individuals or couples, or in group settings. Although the model (theory) behind each of these therapies is slightly different, the approaches have important shared characteristics that go some way to explaining why they are well received by individuals who have mood swings:

- The model of the therapy is shared between the therapist and the individual.
- The model provides a framework for understanding the mood disorder and its impact on the individual.
- The model is used to develop a unique picture of each individual's experiences and problems. It recognizes that no two people have identical needs.

- The main aim of therapy is to develop an individual's self-management skills.
- The therapy is relatively brief, and aims to enable the individual to effectively deal with their own problems.
- The interventions and techniques used to help a person change follow a logical sequence (work on the here and now, then plan for the future).
- The therapist and the individual work together to test out the ideas discussed in therapy by setting up real-world experiments.
- The therapist and individual work in partnership to discover what is helpful or unhelpful to the individual.
- The individual leaves therapy with a range of skills and knowledge that they can apply independently.
- Credit for change lies firmly with the individual, not the therapist.

You will notice that this list says more about the style of the therapy (a collaborative, problem-solving approach) than about the particular interventions that are employed. My experience of working with individuals with mood disorders suggests that *how* the therapy is conducted is as important as *what* techniques are tried. One of the appeals of CBT for many individuals is that it is low on advice and high on self-discovery and self-management.

Many of the strategies used in CBT are also applied in BFT and IPSRT. Alternatively, you may decide that you feel more comfortable with an entirely different approach. However, given the lack of research evidence, it may be worthwhile exploring whether any other therapy you consider has similar characteristics to those listed above, which have been shown to be effective.

The rest of this book will draw on the techniques used in CBT to try to help you to overcome your mood swings. As indicated in the list above, to begin this process we need to explore a CBT model of what happens to an individual at risk of a mood disorder, and look at how to apply this model to your own situation. This is the subject of the next chapter.

Summary

- The primary aims of treatment are to reduce symptoms, restore functioning, and prevent relapse
- A combination of medication and psychological support is likely to be more effective than either approach on its own.
- Medications used for acute mania include a *mood stabilizer* in combination with an *anti-psychotic* medication or a *benzodiazepine*.
- Medications used for acute depression include a *mood stabilizer* in combination with an *anti-depressant*.
- Long-term treatment with a *mood stabilizer* such as lithium, carbamazepine, or valproate is usually recommended to reduce the frequency or severity of recurrent episodes.
- Psychological inputs that may help include:
 - informal support from a social network;
 - regular contact with a self-help group;
 - long-term contact with a mental health professional.
- Psychological therapies shown by research to be effective are:
 - family therapy;
 - interpersonal therapy;
 - cognitive behavior therapy (CBT).



Cognitive Behavioral Approaches to Mood Disorders

This chapter will take you through the key elements of the cognitive behavioral model and then highlight how this may be applied to your own situation. The chapter ends with a brief overview of the main issues that can be targeted with techniques derived from cognitive behavior therapy (CBT).

A Model of Mood Disorders

In the first chapter of Part One we noted that the thoughts (or images) that go through an individual's mind largely determine their emotional response to an event. We also explored how events, thoughts, feelings, and behavior are linked together. When we went on to review the causes of bipolar disorder, we found that an individual's beliefs about themselves and their world influence which life events are stressful to them. Then, in the last chapter, on treatment, we noted that an individual's attitudes and beliefs about medication affect their adherence to treatment.

The term "cognitive" is often used to describe these thoughts and beliefs. Both are key components of the model of mood disorders.

How Do We Develop Beliefs?

Our beliefs usually develop during childhood. We start to develop a set of rules for living from how people act or react toward us, or from what we learn by observing other people's interactions. The attitudes and beliefs of family members, school friends, teachers, and other people in our community also influence our early learning experiences and start to shape what we believe about ourselves and our world.

Even in infancy we start to notice repeated patterns in the responses and attitudes of others. These patterns influence the beliefs we develop. Most of the beliefs we hold are quite adaptive, that is, helpful in guiding our attempts to be considerate and well-balanced individuals. However, some individuals' experiences during this early stage of their cognitive and emotional development may lead them to evolve rules that are maladaptive (dysfunctional) and have an unhelpful influence on how they act and react. Here are some examples that illustrate this point.

Please try harder

Judith is ten years old. She lives at home with her parents but her father, a successful businessman, often has to travel away from home. Judith has been doing very well at school, much to the delight of her father. At the end of the school term, Judith returns home with a glowing school report. She has grade As for all subjects except mathematics, where she achieved a B grade. She is keen to show the report to her father. He eventually returns home – late, tired, and somewhat preoccupied with a meeting he has to attend early the next day. He opens Judith's report, glances through it and then says: "Your grade for mathematics is a bit disappointing, what happened there? It's a shame it's your weakest subject, some people say that maths is the best measure of a person's intelligence. Oh well, you'll have to try harder next time . . ."

Over the next year Judith works hard at mathematics. At times she feels rather anxious about her ability to do this subject, but her teacher is encouraging and seems pleased with her work. At the end of the year she returns with her school report. Judith has a grade A for mathematics. Her physical education teacher (new to the school that term) has given her a grade B (the report does not show that this is the top mark this teacher gave; the rest of Judith's classmates got a grade C). Judith's father examines the report. He says nothing about her grade A in mathematics, but then says: "Shame about your physical education mark. School isn't just about being a good academic, you know; a fit and healthy body is just as important as a sharp mind."

This scenario is somewhat artificial, as it does not describe other aspects of the intervening period in Judith's life. However, on the basis of the information given here, consider two issues. What beliefs do you think Judith might have developed about herself through these experiences? What might she decide she has to do in future to be valued by other people?

The ideas that you might identify include "I'm not good enough," and silent rules such as "In order to be liked/loved, I have to be successful in everything I do." If Judith did grow up with these beliefs, how might she react as an adult if she failed to get an expected promotion at work?

Unhappy families

John is an only child of seven years of age who lives with his parents. For as long as John can remember, home has not been a happy place: his parents are constantly shouting at each other and his father has left to live elsewhere for a while on two previous occasions. Each time his father has left, John has had no idea why his father has gone or if he will return. Neither of his parents has discussed these departures or any other issues with him. However, at various times John has been shouted at, ignored, and/or neglected by his parents.

What beliefs might John have about himself if he was shouted at, ignored, and/or neglected? Given that his father left home twice without indicating when he might return, what beliefs might John develop about other people?

John's beliefs about himself could include: "It's my fault," "I'm not important," or

“I’m unlovable.” With regard to other people, John may develop beliefs like: “People will leave me,” or even “People cannot be trusted.” If these ideas are accurate reflections of John’s beliefs, how might he react in adulthood if his first serious girlfriend leaves him?

Taking the child’s-eye view It may take some time to grasp the ideas discussed in these examples, particularly as you need to remember to put yourself in a child’s place and to understand what they would make of these situations. They do not have the wealth of experience and knowledge that you, as an adult, have accumulated. They are unlikely to make sophisticated judgements about the adults involved in the scenarios. Also, a child is rarely in a position to demand an explanation of what is happening; if no one tells them what is going on, they have to draw their own conclusions.

It is important to note that fixed, maladaptive beliefs do not tend to develop on the basis of a single incident, but most often evolve from repeated exposure to similar situations. In rare cases, however, a single event has such a powerful effect that it alone shapes a person’s beliefs about themselves or other people. On a more positive note, the environment in which an individual grows up may also include protective factors (for example, a parent, grandparent, or teacher who is supportive). So, even if an individual is exposed to adversity, they do not always grow up with low self-esteem or unreasonable expectations of themselves.

How Beliefs Operate: Prejudices

As observers of the above scenarios, it is easy for us to pause and reflect on the interaction between individuals, to take a balanced view of the information (evidence) available, and to view these incidents within a broader context of life experience. However, an observer has the advantage of being distant or detached from what is happening. If you are the person in the middle of a situation, it is not always easy to take a step back and look at it in a wider perspective: we often seem to react spontaneously or automatically. Our beliefs have influenced us for so many years that we are not usually aware that they drive our thinking (and thus our moods and actions). Not only do we fail to notice them operating, we never seem to question whether they are accurate or realistic.

The best explanation of how to understand the influence of maladaptive beliefs on a person’s life was put forward by two cognitive therapists called Christine Padesky and Kathleen Mooney. They suggested that you should think of a maladaptive belief as a prejudice you hold against yourself. People who hold prejudices are blind to how unrealistic or irrational their belief is, but it does influence their lives. For example, some common cultural stereotypes are that Americans are loud, and that the English are “cold fish” or “rather aloof”. Comments along these lines may seem amusing, but supposing an individual has grown up with a strong belief that the English are aloof and unfriendly and holds a prejudice against English people. If they meet some English people who are not very friendly toward them, what would they conclude? Most probably, that they were right all along. Furthermore, they now have evidence to reinforce their prejudice.

Now let us suppose the same individual meets a group of people at a party who are fun-loving and very friendly and welcoming toward – and they turn out to be

English. How does the person with a prejudice against English people maintain their negative view in the face of this contrary evidence? The classic pattern is that they:

- fail to register that the people are English (*don't notice it*),
- make excuses such as suggesting the English people were behaving differently because they were on holiday (*discount it*),
- tell themselves that, as some members of the group had Scottish and American relatives, maybe they were not genuinely English (*distort it*),
- simply state that this group “are the exception that proves the rule” (*make an exception*).

This example shows that if a person holds a prejudice (a rigid, maladaptive belief), they readily accept evidence that confirms their view. However, when they come across contrary information they ignore it or, without realizing, begin to adapt (distort) it so that it too fits with their belief system.

How prejudiced beliefs can work against you Having explored the principles of how prejudices operate, let us apply these principles to the underlying beliefs that individuals hold about themselves.

Imagine a person's early childhood experiences led them to conclude that “I am not likeable.” This belief (self-prejudice) may lead them to avoid social interactions, so that they are rarely exposed to evidence either to support or to refute their idea. If they are unfortunate enough to encounter someone who dislikes them, then their belief is reinforced, their mind is filled with negative thoughts, and they may begin to feel sad. What if someone is nice to them and seems to like them? How do they react to this event? Sometimes they do not notice that the person is being kind. If they do notice, they may briefly feel happy, before doubts begin to enter their mind. Typical thoughts reported by such individuals include: “They are only doing it because they feel sorry for me,” or “They probably won't like me when they get to know me.” The person once again begins to feel sad. For some, these doubts may also influence their behavior, for example, preventing them engaging in social activities with a potential friend. Their self-prejudice has won again.

It is important to stress that only very rigid, unhelpful beliefs are likely to lead to problems. For example, a certain degree of perfectionism may help us to perform tasks to a desired standard. However, a fixed belief that, “Unless I do everything absolutely perfectly, then I am a failure” can obviously put a person under a great deal of pressure. It may inhibit rather than encourage them to achieve what they set out to do, and they may perceive evidence of having “failed” across a variety of situations – at work, at home, or in personal relationships. For a perfectionist, even relatively minor events that many other people would regard as unimportant irritations can be significant stressors. If the individual is also vulnerable to a mood disorder, these stressors may push them into a vicious downward or upward spiral.

Changes in mood may also change what aspects of ourselves or our environment we attend to, and this may activate an underlying belief. For example, if a person feels depressed, they will tend to notice how they keep failing to live up to their perfectionist standards. If a person is going high, they focus on their perceived achievements (e.g. producing a large number of business plans for schemes they wish to undertake), while at the same time, failing to attend to evidence that suggests they are not perfect (e.g. some documents are incomplete, or the schemes are unlikely to

be financially viable).

As well as a degree of perfectionism, other common themes in the beliefs of individuals who experience mood swings are a desire to be approved of by other people, and a wish to be in control of their lives and important situations. These beliefs are not unique to individuals at risk of mood disorders: similar ideas are very common in the general population. However, knowing what types of beliefs you hold will give you clues as to how you may act or react during upswings or downswings. For example, if you like other people to approve of you, when you are depressed (mood) you may worry that you are not liked (thought) and avoid people (behavior). When you are high (mood) you may seek out the company of important strangers (behavior) because you think they will strongly admire you (thought). If you wish to be in control, depression may be associated with a sense of powerlessness as you constantly feel that you have no influence over events; when you are high you may become angry or irritable with those who try to prevent you pursuing risky ventures.

Are you prejudiced against yourself? To begin to get a sense of your underlying beliefs, try to complete the following three sentences (again, this idea comes from Padesky and Mooney):

“I am . . .”

“People are . . .”

“The world is . . .”

Try to use a single word, or the minimum number of words you can, for each belief. Beliefs can usually be captured in one sentence rather than a paragraph.

Do not worry if this task seems difficult at this point. As mentioned previously, we are often not aware of our underlying beliefs, as they operate as “silent rules” in adulthood. This is particularly true when in a normal mood state. If you did manage to complete the sentences, you may wish to pause and consider whether you have noticed the influence of any of these underlying beliefs on your recent actions or reactions.

It's The Thought That Counts

The relationship between automatic thoughts and underlying beliefs Underlying beliefs are present throughout our lives and operate across a variety of situations. A particular maladaptive belief will be activated by events that have some connection with the belief. For example, a silent rule that “I am not likeable” may become activated by the break-up of a personal relationship or by receiving negative feedback from a work colleague. The immediate (or automatic) thoughts that we have about each event or experience apply to what is happening there and then, and help dictate our emotional response at that moment.

A key characteristic of automatic thoughts is that they are “situation specific” – that is, the exact same thought does not usually recur again and again in different environments. However, there may be a common theme that links the thoughts together. Identifying this theme may provide important insights into an individual's underlying belief. For example, a person who is vulnerable to anxiety may find a number of situations difficult. They may find flying in an aeroplane is associated with anxiety, because of thoughts such as “The plane may crash.” They may find walking

a short distance on their own late at night equally anxiety-provoking, because of thoughts such as “Somebody may attack me before I get indoors.” The thoughts are unique to the event; but the common underlying theme is that the person regards the world as a potentially dangerous place. Their reaction to perceived danger is anxiety. Furthermore, the level of anxiety that a person experiences in response to such thoughts may prevent them doing things, such as going out on their own.

Types of automatic thoughts Individuals who are depressed find that their automatic thoughts are dominated by themes of loss and failure. They view themselves as weak, they see their world as full of negative events, and they are drawn to information that they think demonstrates that their future is bleak. This negative style of thinking about themselves, their world, and their future (called the *negative cognitive triad*) further increases feelings of depression and helplessness, and will often lead them to avoid potentially uplifting situations. Thus automatic thoughts powerfully affect the individual’s quality of life; and yet, these negative thoughts are often inaccurate interpretations and represent a selective view of the available information.

It is important to emphasize that this “tunnel vision” is not deliberate. All of us have automatic thoughts in response to the situations we encounter, and many of these thoughts are accurate interpretations, but some are not. We do not pick and choose when to distort our experiences. However, if our thinking *is* distorted it tends to promote more extreme emotional responses to events or situations. Automatic thoughts occur at a conscious level, but many individuals only become aware of their thoughts after they have learnt to focus on what goes through their mind if their mood changes. Once unhelpful automatic thoughts are identified, it is possible to modify them with resulting benefits for mood and behaviour.

Although there are differences in the automatic thoughts that individuals report, the types of thinking errors that occur (sometimes called cognitive distortions) are surprisingly consistent. Individuals may record that they have a set pattern of distorted information processing (e.g. always jumping to conclusions), while others find that their thinking shows many different errors. Some of the most commonly reported thinking errors are described below. You may like to assess whether you have ever thought in any of these ways:

- *All-or-nothing thinking (extremism)* Do you ever look at things in black-and-white terms? Is there any room for doubt, or do your self-statements demonstrate an extreme view of the world? Can you cope with the “grey area” in the middle where things are neither brilliant nor dreadful? Examples of extremism include: “It’s absolutely awful,” “It’s totally perfect,” “That should never happen,” “You must always get it right.”
- *Overgeneralization* Do you ever come to sweeping conclusions based on one minor event or a small piece of a larger puzzle? Do you ever assume that if something happens once, it will always happen? If so, you may be engaging in overgeneralization. Examples of such statements are: “I’ll fail the entire test,” “I’m too quiet, people will never like me.”
- *Maximization and minimization* Do you find yourself putting huge emphasis on either the strengths or the weaknesses of a person, or the good or bad features of an idea? In depression, people exaggerate the importance of minor flaws, making statements such as “I’m ignorant,” or underestimate their qualities: “They’re

mistaken, I'm not really a generous person." In contrast, when individuals are high or elated, they overestimate the gains and underestimate the losses associated with their ideas: "I can't go wrong," "They'll love it."

- *Mind-reading* Are your moods or actions ever influenced by a belief that you know what other people are thinking about you? In reality, we may have a general idea about what a person might think, but we do not have any special powers that let us know exactly what is going through their mind. However, this thinking error is very common and can cause distress. Examples of mind-reading error are: "She doesn't like me," "He only said that to make me feel better."
- *Jumping to conclusions* Do you ever try to guess how things will turn out in the future without weighing up the evidence? When individuals are depressed they tend to predict negative consequences and assume catastrophic outcomes, making statements like: "I know it's going to be awful," "Things are bound to go wrong." Alternatively, when individuals are elated they may predict everything will be wonderful: "If I give up work and buy a boat, I'll be happy for ever."
- *Personalization* Do you find yourself tending to take responsibility for everything, particularly blaming yourself for things that go wrong? Classic self-statements reflecting this cognitive distortion are: "It's my fault," "I'm a bad father."

Having noted the different thinking errors, it is worthwhile trying to recall any thoughts that went through your mind when you experienced a recent noticeable shift in your mood. Can you write down your mood state then, and any of your automatic thoughts? If you can recognize and record any of your automatic thoughts, is there any evidence of cognitive distortions? For example, personalization may generate guilt; jumping to conclusions about the future may spark off anxiety; all-or-nothing thinking may be associated with depression; mind-reading that another person is not going to treat you fairly may give rise to anger.

Automatic thoughts and underlying beliefs are the key cognitive elements of the model of mood disorders. They are intimately linked with changes in mood and response, and also with an individual's physical functioning and quality of life. How all these aspects link together, and how cognitive behavior therapy may be used to break into this cycle, are described below.

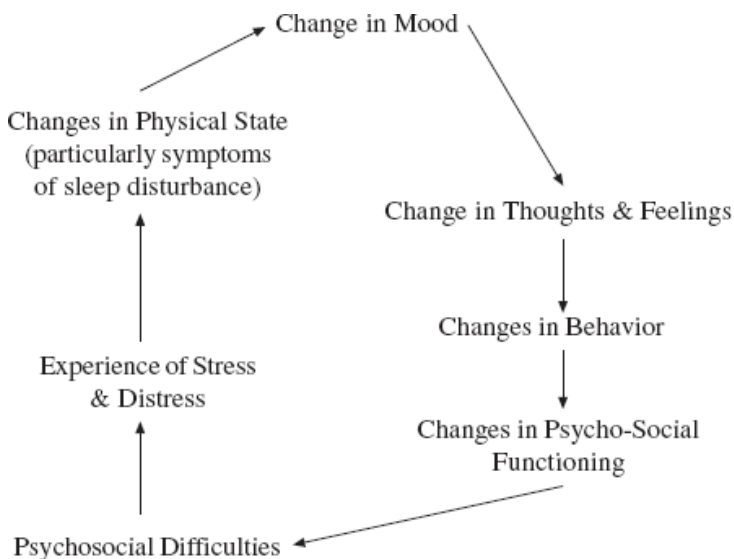
The Cognitive Behavioral Cycle

Maria holds a belief that the world is a dangerous place. She also believes that, if her awful predictions come true, she will not be able to cope on her own. Maria constantly encounters events that generate unhelpful automatic thoughts about danger or not being able to cope. These lead to repeated experiences of intense anxiety. This begins to affect Maria's psychological and social functioning. She starts taking time off work, which leads to negative thoughts such as "I'm a coward" and "I'm useless." This promotes feelings of sadness and depression. As well as being unable to get to her workplace, Maria is no longer able to attend social gatherings. Unfortunately, she eventually becomes unemployed and loses contact with friends. This has a number of associated problems, not least financial difficulties and social isolation. These conditions cause Maria even more stress (through exposure to additional negative experiences and situations) and distress (negative reactions to these difficulties), leading to loss of sleep, and other

physical symptoms associated with low mood (e.g. not eating). These symptoms in turn lead to Maria feeling more depressed.

You can see from this example how the cognitive behavioral cycle influenced all aspects of Maria's life. The starting point was activation of her underlying beliefs. In individuals who also have a biological vulnerability to develop a mood disorder, the cycle could also start with a disruption in circadian rhythms or a change in their physical and emotional state. No matter what the starting point, once the cycle begins, the changes and difficulties that occur are similar for each individual. Mood shifts in turn lead to changes in how that person thinks, feels (worsening depressed mood, or depression compounded by anxiety or irritability, etc.), behaves, and functions. This pervasive effect on a person's functioning and quality of life is demonstrated in Figure 4. Another example is given below for you to follow using the diagram.

Figure 4 The cognitive behavioral cycle



Duncan was a 42-year-old businessman. His business was struggling financially (stress). Duncan was worrying about this and was not sleeping (physical symptom). However, with this reduction in sleep he noticed he was feeling rather better in his mood (mood change); he became optimistic that he could solve the problems of the company by increasing the cashflow through a few "quick deals" and some "creative thinking". He thought he was "a genius": he had a plan to use some money to invest in a mink farm (changes in thoughts and behavior), and would cover this venture by "generating" some additional resources from his family income. He would use his own salary to place bets at the local casino. Duncan became increasingly preoccupied with these schemes and spent less and less time at home. His wife was frustrated that he was not around much, and that when he was, he seemed "distracted" (change in psychosocial functioning). He

decided not to tell his wife about the casino as he thought she would “worry too much” and “be a wet blanket”. The mink farm scheme failed, and Duncan lost increasing amounts of money at the casino. His mood shifted from elation to irritability, and one of his employees took out a complaint against him because he had been rude and angry with her during a meeting. His problems were compounded when his wife confronted him with the household bank statement: they had a large overdraft and the bank manager wished to see them (psychosocial difficulties). As the tensions at work and at home continued and the financial problems of his company and his personal overdraft got worse, Duncan began to feel tense, worried and depressed (stress and distress).

You may now wish to see if you can apply this model to your own recent experience of mood swings, both the ups and the downs. To help you, additional blank copies of this diagram are included in the Appendix (p. 224 and 225).

The Aims of Cognitive Behavior Therapy

CBT aims to teach individuals to intervene at key points in the cognitive behavioral cycle. It encourages individuals to cope with mood swings by helping them to:

- understand their biological and psychological vulnerability factors, particularly their own underlying beliefs, and how these influence their well-being;
- identify and understand the nature of stress, particularly events that activate underlying maladaptive beliefs or events that disrupt their social patterns (social rhythm disrupting events);
- use self-regulation to reduce distress (such as the early symptoms of a mood swing), stabilize their mood, and reduce high-risk activities such as excessive use of alcohol or illicit drugs, or irregular adherence to medication;
- use self-management strategies to overcome intense mood swings by altering their active responses and identifying and modifying unhelpful automatic thoughts;
- develop an action plan to deal with early warning signs and symptoms, so that they have a greater chance of averting an episode of mood disorder;
- develop problem-solving skills that can be applied to a number of issues, such as overcoming the negative consequences of a “high”, and improve their day-to-day functioning and quality of life.

Reading this description may lead you to think there is too much to do, which in turn may make you feel anxious. However, there are a number of issues to bear in mind. First, remember that CBT is a *step-by-step approach*, so you only need to look at one issue at a time. Second, CBT is a *flexible approach*: not everyone reading this book will want or need to achieve all the aims on the list. Third, the advantage of using this book is that, if you choose, you might use it for a while, then have some breathing space before tackling other issues. Fourth, and very importantly, CBT recognizes that everyone is different and that you will need to decide which of these aims concern you most. Finally, you will be in the best position to judge which approaches work best for you.

To help you think through your own needs, you may like to look back at the list of aims above and identify those that are really important to *you* and which *you* may

want to work on. Again, it is really helpful to write down your list of priorities.

A Note of Caution

The next three parts of this book examine some of the cognitive and behavioral techniques that you may use to tackle some of your problems. Most of these techniques are also used in a course of CBT when a therapist and client work together. Some of you reading this book will find working alone easier than others. Practice and regular revision of the techniques described undoubtedly helps. It is a good idea to review the aims of each part of the book and then to read through each section a few times, perhaps making notes on the key points. Try to be clear in your own mind what each technique is about before testing it out in practice. Remember, there will be an element of trial and error, so it is useful to look on each attempt as an experiment. If something doesn't work out as you hoped, try to review exactly what happened, and what you can learn from this. Could you adapt the technique to increase the chances of the "experiment" succeeding next time? This approach is more productive than simply giving up and thinking the techniques won't help you.

Even with supreme effort you may struggle to use every technique effectively. Please do not be hard on yourself if you find some things difficult. This does not imply that you are less able than other individuals, or that you have failed. Not all techniques are equally helpful for all individuals. Some people may simply find it hard to keep going on their own, and may decide to seek professional support. Again, this is entirely appropriate. There is no rule that says a person has to solve all of their problems by themselves. This may be particularly true if you have a long history of mood disorder, if you have very intense swings, or if your problems have proved difficult to handle in the past.

Lastly, this book does not try to cover every aspect of every problem that every individual with a mood disorder has ever experienced. Some issues have been omitted because I did not think we could deal with them in a self-help book. The obvious example of this is the management of psychotic symptoms, as individuals with these invariably need more intensive support and treatment. Other issues have been left out because of the constraints of space, or because of my own ignorance. I anticipated that you would not want to plough through a book of 2,000 pages, so you will appreciate my decision regarding the former. On the latter point, I can only emphasize that this is still a relatively new area of clinical and research work, and I still have many things to learn about mood disorders and their management. With this in mind, you may wish to complete the feedback questionnaire at the back of this book to help me and my colleagues learn from your experiences of using this self-help programme.

Summary

- The term "cognitive" is applied to automatic thoughts and underlying beliefs:
 - automatic thoughts are situation-specific;
 - underlying beliefs are silent rules we apply across many similar situations.
- The cognitive behavioral model of mood disorders suggests that:
 - An individual's emotional response to an event is dictated by their automatic thoughts about that situation.

- The content of the thoughts is determined by a person's beliefs about themselves and their world. Unhelpful automatic thoughts demonstrate common patterns of cognitive distortion.
- Underlying beliefs develop from early learning experiences. Maladaptive beliefs operate like prejudices we hold against ourselves.
- Situations that activate maladaptive beliefs generate unhelpful automatic thoughts that in turn affect an individual's emotional and active responses.
- These responses may precipitate further difficulties in how a person functions, leading to psychosocial problems, stress, and distress. The end point may be changes in physical state as well as further emotional disturbances.
- The cognitive behavioral cycle can be precipitated by:
 - activation of underlying beliefs;
 - circadian rhythm disruption or other physical changes that lead to sleep disturbance.

Once the cycle is established, all aspects of an individual's life are affected.

- Cognitive behavior therapy (CBT) aims to help people identify and manage the causes and consequences of the cognitive behavioral cycle of mood disorder.
- Not everyone will find the techniques described in this book easy to use or helpful.

PART TWO

Learning How to Cope: Understanding Mood Disorders and Implementing Basic Self-Management

Aims of Part Two

At the end of reading Part Two of this book, I hope you will have gained a greater understanding of mood disorders and the key elements of self-management by:

- Learning about life charts, symptom profiles, risk lists, and the key information you need to have to become an expert on your problems.
- Developing an understanding of self-monitoring of mood and activities.
- Reviewing how to distinguish between normal and abnormal moods and behavior.
- Learning about the principles of self-regulation and developing a regular pattern of activities that is acceptable to you.
- Understanding additional approaches that may further improve your self-regulation, e.g. reducing your use of alcohol and stimulants.
- Learning how to identify and overcome common barriers to medication adherence.

Becoming an Expert on Your Mood Swings

In the first part of this book, we reviewed what is known about different types of mood swings and the stress–vulnerability model. We now need to use this information as a framework for exploring your personal experiences of mood swings. In this chapter we will try to understand the pattern and nature of your mood swings, and the stressors or other factors that may affect their frequency. Lastly, we will try to identify what other information you need to extend your own knowledge and understanding of these problems.

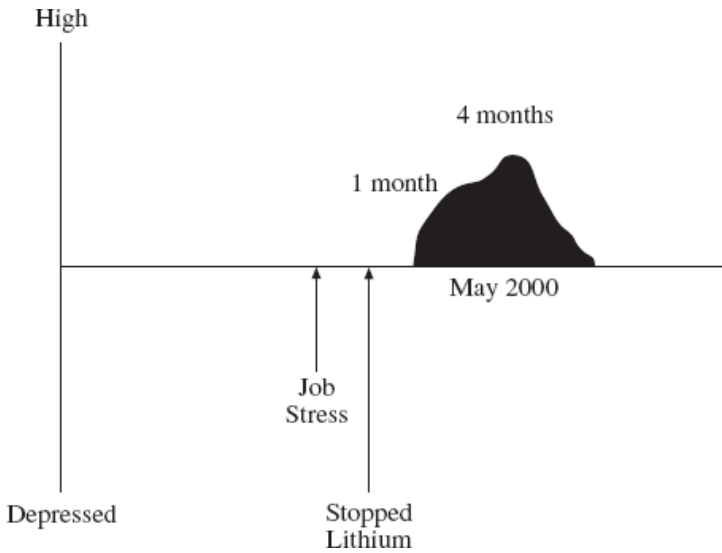
Constructing a Life Chart

To understand your mood swings, and to develop approaches that should give you more control over what happens to you in future, we need to explore your past experiences. Figure 2 on p. 12 shows the differences in severity and nature of the various mood disorders. This may have given you some insights into your own pattern of mood swings. To get a more detailed, individual picture we need to construct a chart that shows the number and sequence of episodes, and the nature and duration of each one. Information on the influence of life events or medication changes can also be added to this picture. This may seem a tall order; so, to help you understand this approach, I will work through an example.

On the three charts, Figures 5a–c, the horizontal line represents a normal mood state. Using this as a reference point, the further the curve goes away from this line, the more severe the episode. Highs are represented by curves above the line; lows go below the line. The width of the curve gives an indication of the duration of each episode. The closer the curves are together, the more frequent the episodes.

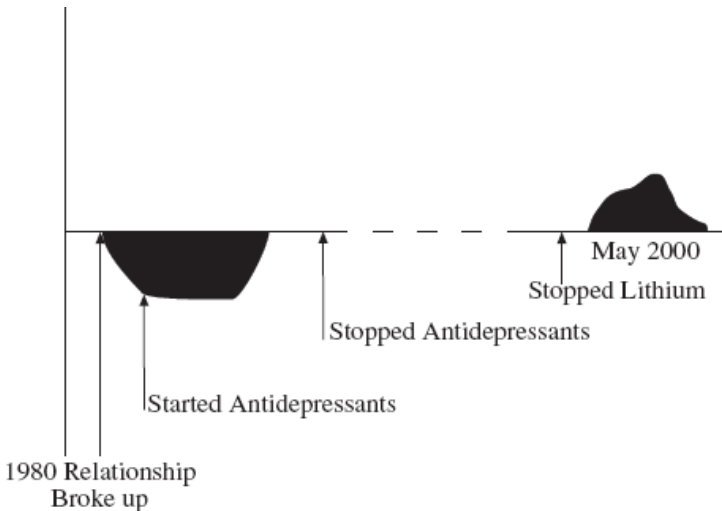
Michael is now 40 years old. His most recent mood swing was in May 2000, when he was admitted to hospital with mania. Michael had been feeling stressed by his job from about March onwards, and a month before the onset of the episode, he had stopped taking the lithium that had been prescribed for him. The episode lasted for four months.

Michael's life chart
Figure 5a



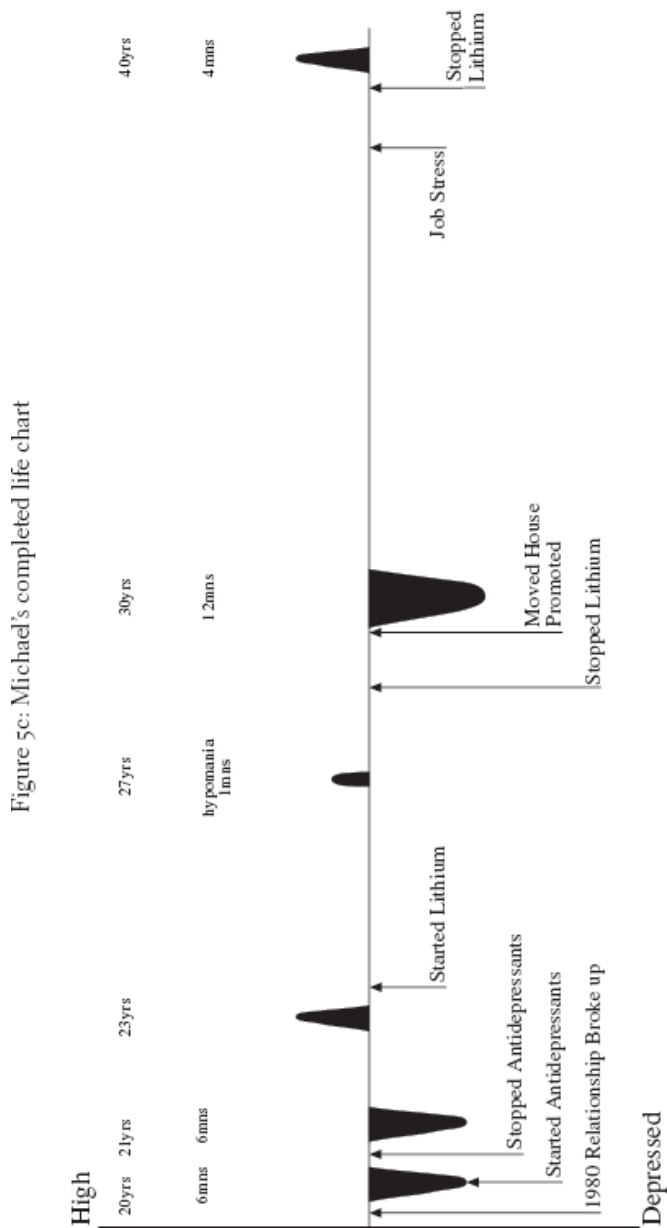
This was not Michael's first mood swing. His first episode had been in 1980, when he was (aged 20). At that time Michael experienced an episode of depression lasting six months that immediately followed the break-up of a two-year relationship. Michael received tricyclic anti-depressants for nearly a year from the beginning of this episode before stopping the drugs of his own accord.

Figure 5b



Between his first and most recent episodes, Michael identified two other episodes of depression of six months and twelve months' duration, one episode of hypomania (one month), and one other episode of mania (three months). It was not

until his first “high” that Michael and his doctor recognized that he had a bipolar disorder. Following this diagnosis, he was prescribed lithium. One other mood swing occurred about two months after stopping lithium; another occurred shortly after moving to a larger home and being promoted at work.



As you can see, the chart gives some important insights into the pattern of Michael's

mood swings, and factors associated with their onset. It is useful to review key events or experiences for at least three months prior to the onset of each episode. It is useful to review key events or experiences for at least three months prior to the onset of each episode. Note that positive life events, such as moving home and being promoted at work, may as be stressful as negative ones, such as the break-up of a relationship, if only because of the disruption of social routines that can go with them.

The vast majority of individuals affected by mood swings who have constructed a life chart tell me they have found the exercise invaluable, and that drawing the frequency, severity, and duration of episodes is helpful in understanding the nature of the problem. So often, it is while doing this that the links between life events and mood swings, or between changes in medication and mood swings, first become apparent. Many individuals have no idea that there is any predictable pattern to their mood shifts until they examine a life chart.

Michael's history may be less complicated than your own, but do not let this deter you from trying to draw your own life chart. The chart does not have to be perfect; it is meant to represent your experiences in a visual format, and does not have to be accurate in every minute detail. Also, many individuals need to revise their charts as they recall additional information about the nature and timing of episodes, or recognize links between events and mood swings.

If you find it difficult to get started on your life chart, the following ideas on overcoming some of the common problems encountered may help you.

What is a "Normal State"?

Some individuals do not feel they ever experience a "normal" mood state. If this is true for you, the reference line will at best represent a relatively neutral state. To help you define this, think of a time before you experienced mood swings, or when you (and the people who know you best) thought you were well or a lot better than you are now. In this state, you were probably able to think more clearly, to function better than you can now, and to cope with day-to-day stressors without major shifts in your mood. You will have had times when you felt more depressed or times when you felt higher. This may not be a perfect definition of "normal state", but this can be used as the midpoint to help you to start the chart.

When was the First Episode?

It is not surprising if you have difficulty pinpointing exactly when your mood swings began. This is particularly true if you have a very long history of a mood disorder. The first contact with the mental health services may come to mind most readily, but it may be hard to recall less severe episodes of depression or contacts with primary care services. If you are having problems here, a simple way forward is to put a question mark next to the first high or low period on your chart to indicate that the date and duration are not certain. Even if some information on the chart is uncertain or incomplete, it is useful to include some representation of each episode.

Also, try to note when you first noticed that things were "not quite right". Many individuals recall that they knew "something was wrong" from an earlier time in their life (e.g. in adolescence), long before their first contact with any health services.

Recording this information on a life chart may help in detecting stress factors and identifying successful and unsuccessful techniques you used to cope with mood shifts.

What Type of Problems Did You First Notice?

Perhaps you can remember clearly when you first noted that “something was wrong”, but it was not described by you or anyone else as a mood swing. Again, it is better to include this information on your life chart rather than exclude anything that might be relevant. The primary aim is to create a graph that helps *you* understand *your* experiences. Some mood swings may be “masked” by medical conditions or by the particular coping strategies used. For example, one person had glandular fever at the age of 13 years. At the time, the “low” that he experienced was not diagnosed as depression but was viewed as part of the physical disorder. In retrospect, it may be that glandular fever acted as a physical stressor that exposed his vulnerability to developing a mood disorder. Another person was regarded as having an “alcohol problem” in her late adolescence. In retrospect both she and her parents realized that she had actually used alcohol to try to alter her mood state.

What about Unusual or “Atypical” Highs or Lows?

Again, the key point is to include information that aids your understanding of what has happened to you. You may need to work on ways to represent mixed states (where you have symptoms of depression and mania at the same time), such as drawing a curve above and below the line in the same place. Likewise, you may want to differentiate euphoric (elated) mania from dysphoric (irritable) mania. A simple way would be to put a letter “E” or “D” within the curve representing the high. In the end, you are in the best position to work out a coding system that works for you.

What if You Are Unable to Remember When an Episode Was or How Long it Lasted?

While the life chart does not need to be perfect, it does help to have some indication of differences between episodes. The more detail you can give to the description of the pattern, the more readily you may be able to pick out key events or themes in what happens to you. If you find it hard to be specific, you may wish simply to estimate the intensity and duration of an episode in terms of mild, moderate, or severe, and short, medium, or long.

If it is the actual timing of episodes that is causing you difficulties, it may help to add another line of information to your chart. This line is used to record key moments in your personal life (a house move, change of job, birthdays, etc.) or memorable moments that you can date in history, such as your favourite sports team winning the last game of a season, or an important social occasion. Using the dates of these key events as guides may help you to place the mood swing as before or after certain events, or at least as occurring between certain dates.

How Do You Fill in the Gaps?

You may find that, despite all your efforts, some information is missing. When a particular episode occurred, or which medication you were taking and for how long, can be hard to recall several years later. Before setting out to find all these details, try writing down a list of all the information you know is missing. Next, go through the list and try to assess whether each item of information is really likely to extend your understanding of your problems. The aim is to make the list as short as possible. Be ruthless about this. Cross off anything that is not critical to your understanding. With each item left, write down why this information is so important to you (e.g. what aspect of your problems it might help you to understand). If there is a clear benefit to pursuing the answer, think of any other details you can recall about your life at that time. These may help you pinpoint a possible source of the missing information. For example, it may be that you want to identify the timing of a hypomanic episode because this was the only time you experienced a “high” and you suspect it occurred shortly after going on anti-depressants, but before you had ever tried a mood stabilizer. However, you cannot be certain about this, nor can you identify the sequence of events. Information about where you were living at the time, who you saw about your problems, who prescribed your treatment, and whether you are in contact with the same health services or living in the same place may help. This information can be used to identify someone who might be able to find this information, or a place where such information may be recorded. If you can identify a potential source, you will then need to think about how and when to approach the appropriate person or organization for this answer. Try to be patient; it may take some time to track down the facts, and sometimes it simply is not possible.

Do not worry if the answer to a particular question is not available. The life chart is initially used to explore the past, but you can continue to use it to describe what happens to you from now on. Knowing what information has been useful in constructing your life chart so far will help you keep an accurate record of similar facts in future.

You may want to approach a person whom you trust and who knows you well to see if they have any comments on the life chart you have drawn. They may be able to fill some gaps you have identified, or they may put forward a new perspective and bring other important issues to your attention. They may recall life events that preceded mood swings that you have not remembered or recorded, or be able to describe the severity of your last depression more accurately than you can. You may choose to show a family member your life chart, so that both of you can understand what it is like to be you, and the types of stress you need to avoid or learn to cope with differently.

The Appendix to this book contains a blank life chart for you to experiment with (p. 226). This is only a guide; you may prefer to use a larger piece of paper, or to construct a somewhat different chart that suits your own needs better.

When you have completed your chart, examine it carefully and answer the question: *“What have I learned about my mood swings and about myself from this exercise?”*

If you find it hard to answer that question, you may find the following pointers helpful:

- Do the frequency and type of mood swings suggest that you have a mood

disorder? If so, what is the nature of that disorder?

- Is there any pattern to your mood swings? For example, do they occur at particular times of year, or following certain types of experience or activities?
- Are there any links between events in your life and the occurrence of mood swings? If so, are there any common themes to the life events?
- If you are taking medication for your mood swings, are there any links between changes in your medication and mood swings? Or between stopping medication and your mood swings?
- Over recent episodes, is there any change in the frequency or severity of your mood swings? If so, how have they changed? Are there any longer-term changes in your situation or activities that may have had any impact on this pattern?
- Which episode on the life chart was the least disruptive or had the least impact on your life? Which was the most disruptive or had the greatest impact? What was different about those episodes that made you select them?

The answers to these questions may help you gain a greater awareness of the factors that affect your mood state. You may already understand these issues well, but a life chart can still be very useful in drawing this information together and in communicating to others the key aspects of your own experiences.

Identifying Your Symptom Profile

A common problem for individuals who experience mood swings is that they are not always certain whether they are experiencing a temporary shift in how they feel or whether they are at the start of a “high” or a “low” swing. It is important to be able to distinguish between normal reactions and extreme or unhelpful emotional reactions. Without this knowledge, it is difficult to feel any sense of control over your situation or to be confident about when to use self-management approaches.

To decide whether a mood change is the forerunner of a significant emotional shift (into an episode of mood disorder) requires some detective work. First, we need to know how many different types of mood swings you experience, e.g. depression, euphoric mania, dysphoric mania, hypomania, mixed states, etc. If you review your life chart, you should be able to identify the nature of your different swings. The next stage is to take a separate sheet of paper for each type of mood swing. Then, for each type of mood swing, try to recall and write down the symptoms you experience. These will include the feelings, thoughts, behaviors, and alterations in your day-to-day functioning that you experience, along with any changes in your physical state.

If you are struggling to get started, try to answer the following questions:

- How does your life change when you are “high” or when you are depressed?
- How do your views of yourself, other people, the world, and your future change when you are “high” or when you are depressed?
- What do other people notice about you during these episodes?

Do not worry if some features occur on more than one symptom list; this is surprisingly common. For example, some people feel irritable when they are high or low. The main thing is to try to develop as complete a picture as possible. If you find it difficult to remember some details, try to recall the symptoms from your most

recent episodes, or explore other sources of information. You may wish to discuss what you are doing with a person you trust, as they may be able to help you to develop the list. You can also read through information given in the earlier part of this book, or scan other materials that describe the common symptoms of mood swings. However, ensure you include on your list only those features that *apply to you*.

Some individuals prefer to write each symptom in a more personal way than the descriptions you read in books. For example, rather than writing “irritability” you may wish to write: “I am easily annoyed or irritated, particularly in interactions with family members.”

Table 2 Symptom profile

Highs <i>Elated and irritable</i>	Depression <i>Very depressed and anxious</i>
My common symptoms are: 1 Increased energy* 2 Disinhibited* 3 Increased spending 4 Reduced need for sleep* 5 Easily distracted 6 Very sociable	My common symptoms are: 1 Indecisiveness and procrastination* 2 Feeling slowed down 3 Loss of appetite and weight* 4 Social withdrawal* 5 Poor sleep with early waking* 6 Lack of energy, feeling lethargic
My less common symptoms are: 1 Intense optimism 2 Increased punning and rhyming when I talk 3 Aggressiveness 4 Risk-taking	My less common symptoms are: 1 Pessimism about the future 2 Agitation about minor things 3 Feelings of guilt and worthlessness 4 Thoughts of death

*Early warning symptoms.

Finally, revise your list to ensure that it focuses on the features that occur *regularly* when you go high or low. It may help to rewrite the list with “my common symptoms” listed at the top of the page and “my less common symptoms” at the bottom of the page. On reviewing the list, is it possible for you to say which symptoms occur at an early stage and which come later in an episode? Put a star against any symptoms that are the “early warning symptoms” that your mood swing is getting under way. We will explore these symptoms in more detail at a later stage.

To help you construct your list I have included an example of a “symptom profile” in Table 2. A blank copy is also included in the Appendix on p. 227.

It is particularly important to consult this list whenever you are unsure whether your emotional state has shifted into a mood swing. Rather than ignoring any changes in how you feel, or convincing yourself that nothing is wrong, you can review your symptom profile sheet and check whether what you are experiencing now mirrors information you have already recorded. This can help you reach an accurate conclusion about whether you are developing an episode of depression or a high. It can also be used to help resolve any disagreements with, say, a partner or a member of your family about whether you are okay or not. This information will also be

useful when you are developing your self-monitoring and self-management skills.

Developing a Risk List

The aim of a “risk list” is to make you aware of the factors that may trigger your mood swings. If you review the events, experiences, or behaviors that occurred in the months leading up to an episode of mood disorder, you may be able to identify common themes; or you may notice that similar stressors precede the onset of your highs as compared with your low periods. Again, do not worry if you have not yet been able to identify these triggers; remember that from now on you can start to note key events or activities on your life chart, so that in the future when you look back at it you will more easily be able to see potential links.

If you have noted some key issues in the months preceding some or all of your episodes of mood disorder, try now to list them under three headings:

- life events
- life situations
- personal actions.

Now go back to your life chart and check if any similar events, situations or responses, occurred at other times. Don’t forget to include on your list major life events that can happen to anyone. Even events or situations that seem to be inevitable consequences of everyone’s life cycle (e.g. leaving school or college, changing jobs) may still have relevance to your mood swings.

We are now going to use this list to try to determine what events, situations, and activities put you at high risk of an episode of mood disorder. Later in this book we will explore ways to manage these risk factors.

Having identified a possible list of high-risk events, situations, and activities, the next step is to see whether any patterns exist within each of these three categories.

- High-risk events often have a specific personal meaning because of an individual’s underlying beliefs, or are important because they disrupt a person’s sleep–wake cycle (as described in Part One, these are often social rhythm disrupting events).
- High-risk situations may be positive, such as anniversaries and parties, holidays and vacations, or negative, such as ongoing pressures at home or at work. We may not always know if these specific situations have activated some of your key underlying beliefs or led to a disruption in your social rhythms (e.g. staying up late for a party or changing your daily routines because you are on vacation). However, you may be able to identify recurring types of situation, such as “extended periods of time away from home” or “family celebrations”, which could be the basis for a pattern.
- High-risk activities are often the most difficult for individuals to identify, as to start with you may hardly be aware of their influence on your mood swings. Typical examples are consuming alcohol or using illicit drugs; excessive intake of caffeine or other stimulants; or suddenly stopping prescribed medication. It is important to ensure that any high-risk activities that you record occurred *before* the start of an episode and were not symptoms of the episode itself.

To help you construct a risk list I have included an example (see Box 1) using the information in Michael’s history that we examined at the beginning of this chapter.

Box 1 Michael’s risk list
<i>Risk factors</i> 1 High-risk activities Not taking prescribed lithium 2 High-risk situations Ongoing job stress Getting promoted 3 High-risk events Moving house (?social rhythm disruption) Relationship breakdown (specific personal meaning) ?Getting promoted (?fits here also: is this related to worrying about expectations?)
<i>Other important information</i> e.g. High-risk combinations Multiple major life events (moved house and got promoted) e.g. Protective factors Not sure at the moment

Identifying High-Risk Factors

Here are some additional tips if identifying high-risk factors is proving difficult.

What do I do if I don’t seem to have any high-risk factors? There are two main reasons why you might not be able to list any high-risk factors. The first is that you have not yet identified the factors that were important in the past. This is very common: after all, at that time you did not have any reason to attend to such information. Research has only recently shown that events that disrupt your social rhythms may be important. However, you can start to learn more about your risk factors in the future through careful self-monitoring of events or changes in your activities and behavior.

Second, you may be very sensitive to minor changes in your stress level. The term “sensitive” is not meant to suggest any personal flaw; it can refer to brain activity, as discussed in the section of Chapter 3 on vulnerability factors. If you experience frequent mood swings, it may be that these are triggered by many small changes in your life circumstances or your behavior rather than by fewer, more memorable, big events. Individuals who have frequent mood swings, without all the other symptoms of a mood disorder, often describe this pattern of fluctuations. As described later, in the section on “unhelpful thoughts” in Chapter 9, monitoring shifts in your mood in response to day-to-day events and activities will probably help you determine if this is why you cannot identify any specific high-risk factors.

How can I determine if an event has a specific personal meaning? To some of you, this question will seem foolish. The personal meaning and importance of certain life events may appear to be obvious. However, if we are to develop a list of events that will be used to alert you to the potential development of a mood swing, we need to know in detail why each event that you note was important to you. This will ensure

that you don't only monitor repeated exposures to the same event, but that you are able to spot events that have a similar meaning and impact.

Chapter 5 on the cognitive behavioral model of mood disorders described the development of underlying beliefs and the influence of these "silent rules" on our day-to-day lives. If you were able to identify some of your own rules as suggested in that chapter (by completing the sentences: "I am . . .," "People are . . .," "The world is . . ."), you can now use these to ask yourself if one or more of the events linked to the onset of your mood swings was related to these beliefs. An example is given below.

Greg grew up with the belief that "The world is not fair." He became particularly upset when a reorganization at work meant he had to move to a different office away from other managers of similar status to him. One of Greg's colleagues admitted to being mildly irritated by having to move, but seemed to adapt quickly. However, Greg became increasingly upset. His mind was full of thoughts that he had been "picked on". In the end he became so sad that his boss went to see him. His senior was stunned to find out the cause of Greg's low mood; he explained that he had given Greg the nicest office on the floor as a reward for his hard work.

If no relationship between the events and your beliefs is obvious, you may wish to try the following experiment. Write the event down at the top of a piece of paper and then try to imagine that it has just happened. What goes through your mind? Can you capture your automatic thought and write it down? Be as specific as you can. The next step is to ask yourself this question: "And if that were true, what would that mean or say about me?" (If the thought relates to other people or to your world, simply replace the words "about me" in the question with "about other people" or "about the world".) Write down the next thought that comes to mind and then repeat this exercise, writing down the thought at each stage. Repeating the question three to four times usually brings you to the "bottom line" which often represents your "silent rule". To show you an example of this "downward arrow" approach, I have borrowed an idea from a cognitive therapist called Melanie Fennell who works in Oxford (see Box 2). I particularly like her example because it explores the beliefs of a therapist. In this instance I have adapted her idea and applied it to myself!

If this approach does not allow you to tap into your underlying beliefs or to be specific about why the event has been important to you, it is still useful to include the event on your list as well as monitoring similar types of events. You can also return to this topic at a later stage, after you have explored how the themes in your day-to-day automatic thoughts may also reveal clues about your underlying beliefs.

Box 2 Downward arrow technique

Event: Just re-read notes of a book chapter I've written on self-help

Emotion: Anxious

Thought: That's terrible, no one will understand this, I've been no help at all

Questions to get to the meaning:

Supposing that was true, what would it mean to me?

↓

That people reading it won't benefit

↓

And supposing they didn't, what would that mean to me?

↓
 That I had done a bad job
 ↓
 And supposing I had, what would that mean to me?
 ↓
 That I was a lousy writer
 ↓
 Supposing I was a lousy writer, what then?
 ↓
 Sooner or later I'll be found out
 ↓
 And what does that mean to me, being "found out"?
 ↓
 It means that:
Everyone would know I was no good and despise the fact that I had this chapter published
 and
My previous successes didn't really reflect my ability, they were pure luck

My silent rule: To think well of myself I have to succeed at everything I try

What if the risk factors seem to fit into more than one category? You may have identified a list of events, situations, and behaviors but have difficulty in putting these into the different categories. Do not be too concerned about this. If in doubt, you can include a factor in more than one box. For example, you go away for a long vacation (situation); when away you change your daily routines (social rhythm disrupting event); and on some evenings you drink more alcohol than you do normally (behavior). Six weeks after your vacation you experience a "high". You also know that travelling by plane to your holiday destination and drinking alcohol may both disrupt your circadian rhythms. Rather than trying to guess which high-risk category to put the information in, it is quite acceptable to include all of these factors on your risk list. For example:

- *events:* long-distance air travel, disruptions to daily routines;
- *situations:* being away from home for long periods;
- *behavior:* staying up very late at night, drinking alcohol late at night.

How can these be high-risk factors if they have also occurred at other times when I have not had an episode of mood disorder? Sometimes, you may be unsure whether to include an event on your "risk list" if it is not always associated with the onset of an episode of mood disorder. In general, it is better to include rather than exclude items; you can always put a question mark against them to show that you are uncertain about their importance. The aim of the risk is to alert you to occasions when you need to increase your self-monitoring to determine whether any early warning symptoms develop.

Alternatively, you might wish to consider whether any other (protective) factors were operating that reduced your risk of developing a mood swing despite the presence of a high-risk factor. For example, were you protected from developing an episode of mood disorder on one occasion because you were taking a mood stabilizer regularly, or because you had someone in your life who acted as a confidante and supporter? If this was the case, you could add another category, entitled "potential protective factors", to your list.

Using the information you have recorded on your life chart, symptom profile, and "risk list", you can now check whether there are any differences in the types of high-

risk factors that precede different types of mood swings. If you had difficulty completing the cognitive behavioral cycle (described in Part One) you may also wish to make another attempt now, using factors identified on your “risk list” and your notes on early warning symptoms for your mood swings.

The Appendix of this book contains two blank versions of a “risk list” for you to complete (pp. 228 and 229). As well as space for you to list the different high-risk factors you identify, there is an additional space for you to note other information that is important to you that does not fit neatly into the categories outlined. Some individuals prefer the second version of the list as it can be used to identify factors associated with different types of mood swings.

Even if you cannot identify high-risk factors, you may be aware of the early warning symptoms that mean you are in danger of developing an episode of mood disorder. Through practice, you may be able to detect these symptoms quickly enough to take action to avoid an intense mood swing. Furthermore, any links between events, situations, or behavior and subsequent mood swings may then become apparent.

Key Information You Need to Become an Expert

Research suggests that when an individual experiences a health problem, no matter what type it is, they tend (without realizing it) to organize their thoughts about the problem according to five key themes. These are:

- *Identity*: What is the name given to my problem?
- *Cause*: What is known about the causes?
- *Time-line*: How long will this problem last? Will it recur?
- *Consequences*: What is the impact of the problem on my life?
- *Control*: How can my problem be controlled?

So far, we have examined the nature and history of your problems (*identity* and *time-line*). We have also reviewed the high-risk factors that may increase the likelihood of your experiencing a mood swing (*causes*). However, we have not reviewed in detail the impact (*consequences*) on your life of having mood swings, and we have only just begun to explore the effects on your mood swings of medication or the lack of it (*control*). Part One of this book included a brief review of the evidence for the effectiveness of psychological treatments (*control*), but we have not yet examined how you may implement or benefit from these approaches. Before moving on to use the self-monitoring and self-management techniques, it is important to ensure that you are confident of the *facts* about your own situation.

Gathering evidence to support your ideas about each of these five areas is not recommended simply because it will give you a detailed understanding of your problems (although this is very valuable). It is also important because of the influence of cognition on behavior and vice versa, as discussed in Part One. A person’s view of their health problem will influence how they handle that problem. Misconceptions may lead to the use of inappropriate coping strategies. For example, a person who thinks that their mood disorder will “burn itself out” may avoid reading information that suggests this is not the case and reject medication prescribed to prevent a recurrence. A person’s underlying beliefs will also influence how they view their

mood swings. An individual who believes that “I am weak” may take to the view that their mood disorder is caused by personal inadequacy rather than by the interaction between stress and a biological vulnerability.

To become a real expert on your mood swings you may need to challenge some of your own assumptions about your problems. To complete your own understanding, you may find it helpful to work through the following questions:

Identity

Can you record the name given to your mood swings (e.g. bipolar I disorder)?

Reviewing the information from your life chart and symptom profile may help you do this. If you have noted a name, can you rate on a scale of 0 to 100 how confident you are that this “self-diagnosis” is correct? If your rating is 60 or below, can you identify what the gaps are in your knowledge that are causing you concern? It may be that you can overcome these concerns by gathering additional evidence from the descriptions of mood swings in this and other books, and/or by going over any information given to you by health professionals. If you need further information to come to a decision, when and where will you seek this information? (The more specific you can be about the date and the place the better.)

Cause

What do you know about the causes of your mood swings? Vulnerability factors (such as a family history) that may apply to you are described in Chapter 3 of this book. Your risk list also identifies factors that increase the likelihood of your developing a mood swing. If you do not have information about stress or vulnerability factors, when and where will you gather information to help you understand the causes of your mood swings?

Time-Line

Do you know how long your mood swings last and when they will occur? Again, you may be able to answer this question using your life chart, the early warning symptoms listed in your symptom profile, and your risk list. You may also wish to review the information given earlier in this book (Chapter 2) on the average duration of manic and depressive episodes and the likelihood of recurrence of a mood disorder. Can you estimate your own risk of a further mood swing? What evidence do you have for or against that prediction? If this question is difficult to answer, it may be worthwhile setting yourself a target about when and where you will seek further information.

Consequences

What has been the impact of mood swings on your life? To assess the impact of mood swings on your life you may wish to consider the following:

- *How has your day-to-day functioning changed?* This may include your ability to work, your ability to care for yourself, or the effect on your life of persistent symptoms such as lack of energy.

- *What adverse effects have there been on your interpersonal relationships?* This may include tensions in any current relationships with family or friends, or unresolved issues relating to previous mood swings.
- *What adverse effects have there been on your view of yourself?* This may include lowered self-esteem, or feelings of shame and guilt.

You may have noted some of this information when you reviewed what you learned from constructing your life chart. If it is difficult to answer the questions, you could ask another person if they have evidence of any negative consequences of your mood swings. You can then gather information to support or refute the views put forward. Alternatively, you could ask other individuals with mood swings about their experiences, or read personal or textbook accounts of the consequences of having mood swings. You can then assess how many of the experiences described also apply to you, and make a rating of the impact each item has on your life. It is important to make a realistic judgment as to whether every problem you can think of was a consequence of having mood swings, or whether some difficulties might have arisen in your life even if you did not have a history of mood swings.

Control

How can your mood swings be controlled? It is very important to seek out reliable sources of evidence when answering this question. Much of what is written on the treatment of mood swings represents opinion rather than scientific fact. Also, this is an issue where your beliefs and attitudes are very likely to have influenced your selection of the information to which you have given most attention. We will return to this topic when we explore the barriers to taking medication. The rest of this book takes a scientific approach to the question of control by asking you to experiment with a number of techniques that may help you manage your mood swings.

In summary, gathering evidence on five key aspects of your problem will give you a balanced understanding of your mood swings. This evidence will help you distinguish ideas and hearsay from the *facts*. You may not feel certain how to assess the information before you; so, here is a summary of the likely reliability of different sources. This is only an approximate guide, but it may help you in your efforts. The list is written in rank order, with the first level representing the highest-quality information:

- *Systematic reviews* published in evidence-based medical journals or in electronic form (e.g. the Cochran Database). A systematic review draws together key information from lots of research studies. It excludes studies that were poorly designed or flawed, and then carefully assesses the outcomes for all the people who entered the studies. It will, for example, search out all the high-quality treatment studies for a particular disorder and then work out how well people do with or without each treatment. These are relatively new, so not every treatment for mood disorders has been reviewed yet.
- *High-quality, large-scale multicentre research studies* published in mainstream medical or psychiatric journals. These studies usually conform to the highest standards in research design, with independent ratings of an individual's improvement, and subjects allocated to the treatment groups by a special

procedure called “randomization” (like tossing a coin).

- *Textbooks, leaflets* from established self-help organizations, and the *doctors, clinicians, and professionals* who have read this information. These sources of information are usually sound, but textbooks may be slightly out of date. Research moves on quickly, so by the time the textbook is prepared, published, and read, the evidence may be slightly different.
- *Smaller-scale, randomized trials or research studies reporting on a series of people or single “examples”*. This information is often “hot off the press”; it may indicate new treatments that will come on to the market, or what the next line of research will be into the causes of a disorder.
- *General review articles, information, or statements by people with some experience of living or working with a disorder or problem*. These sources of information are often more accessible to individuals with mood disorders than other sources of data. However, they are open to bias and tend to be less evidence-based.
- *Articles and reports in the news media*. Unfortunately, media reports are strongly influenced by the individual writing the article or making the film. They may put a particular “spin” on the information they present to make the report interesting or eye-catching. This can introduce biases or distortions.
- *Unattributed comments, remarks by friends of friends, “favourite sayings” of family members or anecdotes*. These views may not be wrong, but there is no reason for believing that they are right, either.
- *“I just know!”* Alas, this is not an evidence-based answer. How do you know? What evidence do you have that makes this idea a fact?

It may not be feasible to try to acquire copies of systematic reviews or research reports; and even if you can get hold of them, they tend to be full of jargon and can be quite heavy going. You will probably find that textbooks, books dedicated to discussing mood swings, and leaflets and information from self-help and other organizations will provide you with most of what you want. Doctors, professionals, and others with access to this information may also be able to answer your questions about issues of concern to you, or to help you if you do not understand some of the items you have read. Your efforts will definitely be worth while. Becoming an expert on the facts about your mood swings enables you to make informed decisions about how to manage your problems.

Summary

Becoming an expert on your mood swings involves four key steps:

- Developing a detailed understanding of your past experiences by constructing a *life chart*;
- Developing a detailed knowledge of your experiences during different mood swings by composing a *symptom profile*;
- Developing a detailed knowledge of factors that may precipitate your mood swings, particularly noting on your *risk list* information about:
 - high-risk events;
 - high-risk situations;
 - high-risk behaviors.
- Gathering evidence that allows you to answer five key questions:
 - *identity*: What is the name given to your experiences?

- *cause*: What is known about the causes of your mood swings?
- *time-line*: When might episodes occur?
- *consequences*: What has been the impact of mood swings on your life?
- *control*: How can your mood swings be controlled?

Self-Monitoring and Self-Regulation

The previous chapter explored some of the details of mood swings that have caused you problems in the past and the factors that may trigger these episodes. If you are to prevent major mood swings in the future, you will need to be able to apply that knowledge. You will also need to be able to identify any shifts in your mood, behavior, and thinking from one day to the next, and be able to judge if these are normal or abnormal. This chapter begins equipping you to do this by examining methods to monitor your moods and activities, and then exploring some basic self-regulation techniques that may help stabilize your day-to-day mood state and functioning, and reduce the risk of minor changes spiralling out of your control.

Monitoring Your Moods

We all experience fluctuations in our emotions, and it is not unusual for one's mood to change several times over the course of a single day. However, if you experience mood swings or a mood disorder these emotional shifts need to be closely monitored, for two reasons: first, to understand better the events and thoughts that precipitate mood changes; second, to learn to distinguish between mood shifts that may be the forerunner of a major mood swing or an episode of mood disorder, and those that are within normal limits. Knowing how to identify the latter is particularly important. Individuals with mood swings need to feel confident that they can experience a normal range of emotions without fearing that they are about to be plunged into a problematic episode. Furthermore, they need to be able to communicate the differences between their normal and abnormal moods to others. It is quite common for the friends and family of someone with a mood disorder to worry unnecessarily and express concern about the person's mental state every time the individual appears to be cheerful. A shared understanding of the difference between normal and abnormal mood shifts can help avoid or at least reduce tensions within these relationships.

A weekly mood chart is a useful tool that allows mood shifts to be identified and monitored on a daily basis. Once you feel comfortable with the process it may help to keep a monthly chart, as this will mean you can quickly review your progress over extended periods of time. The approach has some similarities to that used to construct a life chart, but the information is collected as you go, on a day-to-day basis, so tapping into much more subtle shifts in how you feel.

As with a life chart, a mood graph starts with a horizontal line across the middle of the page, which represents your normal mood state (sometimes called euthymia). In order to build your personalized mood graph, there are a number of key questions to be answered:

- Which moods need to be monitored, and what rating scale should be used to measure shifts in these moods?
- What are the boundaries of normal and abnormal changes in mood, and are there any associated changes in thoughts and behavior (particularly sleep pattern)?
- What events or experiences precipitate the mood change?
- At what point in any mood shift do you need to intervene, i.e. can you identify your “action points”?

Mood Ratings

Before launching into a regular routine of rating your moods, it is important to decide which mood swings cause you most difficulties and need to be monitored. For some individuals this is an easy decision: they suffer from highs and lows that disrupt their life. However, as mentioned earlier in this book, others experience mixed states or dysphoric mania. In these states they are not elated, but may report feeling unhappy or irritable at the same time as being overactive. So they may wish to monitor depressions and episodes of being “hyper”. The critical issue is to decide which mood states *you* need to monitor and to be clear how *you* define each of these moods. A key test of the definition is: Can you describe this mood state to someone else in a way they can understand?

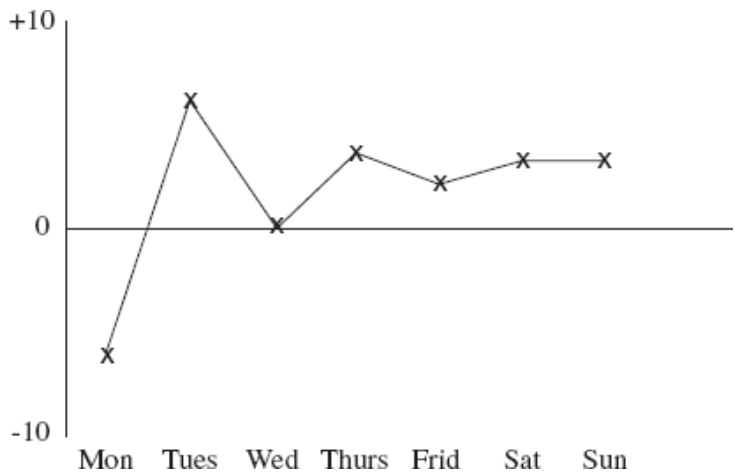
Ideally you should aim to focus on only two or three key moods. Monitoring more than this is difficult simply because of the amount of self-monitoring you would need to undertake. If you feel the need to consider more mood states, it may help to list these different mood states in a notebook and to start by monitoring the two or three moods that are currently causing you most difficulty. After a few weeks, if it is helpful, you could then choose to monitor some of the other mood states on your list. As for how often you need to record a rating, some individuals find that their mood varies so much over the course of the day that it is helpful to re-rate their mood on two or three occasions over each 24-hour period. A morning, afternoon, and/or evening rating may help you to detect changes in your moods.

Assuming that you have identified two key moods to monitor, we now need to construct a scale that best represents the range of variability in each mood state. If you are monitoring lows and highs, you may choose to have a 0 to 10 scale, where 0 = most depressed and 10 = the highest you’ve been. A normal mood state or euthymia would be represented by a score of about 5. However, some individuals (for example, those who experience mixed states) prefer to represent lows on a scale of 0 to -10 (where 0 = euthymia and -10 = severe depression) and highs on a 0 to +10 scale (0 = euthymia and +10 = mania). The diagrams shown in this book use this latter approach (see Figure 6), but it really does come down to personal preference.

The next step is to define the “anchor points” on the scale. Anchor points are defined points on the mood rating scale which describe how you are acting and reacting when you record a particular score. This is crucial as it will help you start to decide when your mood shifts from a normal to an abnormal state. A range of +2 to -

2 could represent your normal day-to-day fluctuations, with scores beyond this range representing greater degrees of disturbance. To define the different points on the scale, you may wish to go back to your symptom checklist and see which symptoms occur commonly when you have a mild, moderate, or severe mood swing. By the end of this exercise you should be able to answer the questions: “If you rated yourself as +6 how would you be in your mood? What activities or behavior would you engage in?” or: “If you rated yourself as -8 how would you be in your mood? What activities would you engage in?”

Figure 6 An example of a mood chart



If this exercise seems hard, you may find that you can develop a clearer picture of the anchor points after a few weeks or months of monitoring the variability in your own moods. In the interim, you may find it helpful to use the list I have provided in Box 3. You can adapt all or part of this list to describe your own situation and experiences.

Boundaries Between Normal and Abnormal States

If you have begun to define the “anchor points” on your mood graph, you may be able to decide quite quickly where the boundary lies between normal and abnormal reactions. However, it is best not to rely simply on your mood as the measure of “highs”. This is because research shows that when an individual is going into a “high” they generally do not attribute their positive feelings to the onset of problems. Almost invariably, it is only in retrospect that the individual realizes that their mood shift was not a sign of well-being but a warning that they were about to lose control.

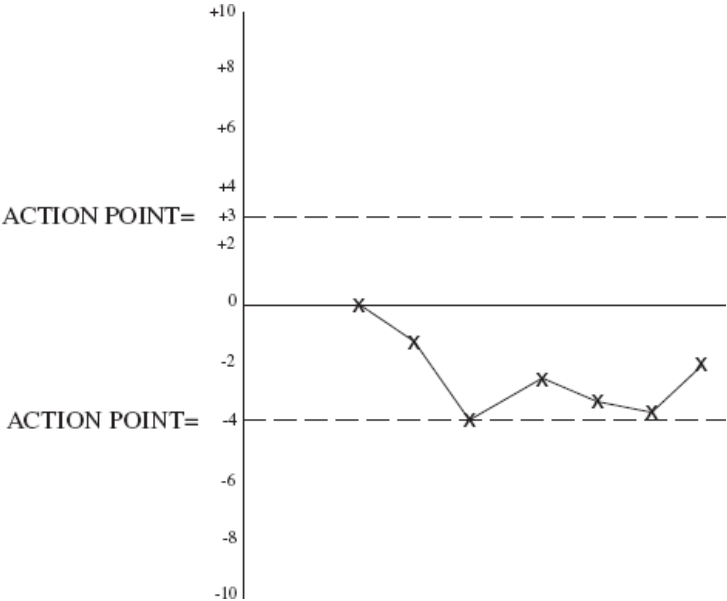
Box 3 Anchor points	
<i>Mood rating</i>	<i>Key characteristics</i>
+10	Totally out of control, psychotic symptoms such as delusions that I rule the world
+8	Out of touch, not sleeping at all, taking major risks e.g. flying lessons
+6	Very overconfident, drinking excess amounts of alcohol, staying up late, not eating much, very impulsive e.g. buying items I don't need
+4	Very irritable, easily get angry if people try to stop me doing things
+2	Increased energy, don't need as much sleep, becoming disinhibited, arranging lots of social activities
0	Mood in balance, regular 7 hrs sleep, eating three meals a day, contented, good balance of pleasurable activities and tasks
-2	Rather flat mood, start to withdraw from people, sleep a bit erratic
-4	Reduced appetite, start to lose weight, concentration very poor
-6	Anxious, starting to avoid everyone and everything, feeling guilty about things I've done in the past
-8	Thoughts of suicide, keep seeing images of my funeral, not eating, virtually no sleep
-10	Very slowed down, can hardly move around, not talking to anyone

For this reason, it is very important to include additional information to describe the boundaries between normal happiness and a “high”. Again for this exercise you will need to review your symptom checklist, and possibly your life chart too. The important thing is to discover what changes in you accompany an upswing that ultimately progresses to a high. You may also wish to talk to someone you trust and who knows you well, as the two of you may then be able to gather the information that will help with this rating. If you are going to seek help, remember to try to listen

to what the other person says to you without viewing their comments as a personal attack. You are discussing the symptoms that occur when you start to go high; they are not criticizing you as a person, simply trying, with you, to construct an accurate picture of your mood swings.

Individuals who have used mood monitoring have also told me that it can be helpful to use the space at the bottom of the mood chart to note any other symptoms that they know can be associated with their highs or lows. For example, one person knew that when she was going high as compared to simply being happy, she would start to become increasingly preoccupied by religious ideas and her relationship with God. She decided that she would note this on her mood chart, as it helped her to distinguish normal from abnormal moods. Other individuals have suggested recording how many hours they sleep at night as sleep disturbance is often an early warning sign of problems to come. Both these options are valid, and in Figure 7 I have shown what a mood graph would look like with this and other information added. However, if you find this diagram too complicated and not very “user friendly”, start by keeping a simple chart that is helpful to you. The crucial point is to tailor the mood chart to ensure it includes the information that *you* need at your fingertips. Simply getting into the habit of monitoring your mood state is an important first step. You can always develop a more complex version at a later stage.

Figure 7 Mood graph including additional information



		Mon	Tue	Wed	Thurs	Frid	Sat	Sun
Medication	Lithium 600mg	+	-	+	+	-	+	+
Sleep	Hours/Night	8	6	5	7	6	5	6
Other Symptoms/Behaviors:								
	Preoccupied by Religion (Highs)	-	-	-	-	-	-	-
	Worry about Money (Depressed)	-	-	+	-	+	+	-
Life Events/Other Information								

The final point in constructing a mood chart is to make sure that the anchor points are spread out evenly. There must not be a sudden leap from normal to abnormal. It is more helpful to see each point on the mood scale as part of a continuum, representing a gradual change from the point before. This means that you can then identify in advance what is likely to happen next if you do not take action (see Box 3). The reason I suggest defining “anchor points” carefully is because I have been caught out using this system in the past. I once had a client who was keeping a mood diary, but we did not clearly identify what each anchor point on the scale represented. I did not realize that for her, +4 (out of 10) was feeling happy, but +5 was mania. Not only did the anchor points on this mood graph fail properly to represent the changes in mood and behavior that she experienced, it gave us no time in which to act to prevent her going into mania.

Other Factors

You may also decide to include on your mood chart information about medication, life events, or other stressors. This can be helpful if you are finding it hard to gather information relevant to your risk list. Many women have commented that recording their menstrual cycle on the mood chart helps them to gauge the impact of hormonal changes on their emotional state.

Action Points

Ideally, you should aim to have about six anchor points on your mood graph ranging from normal through to abnormal experiences of a specific mood state. The next issue is to decide at what point you need to intervene to stop your mood spiralling into dangerous territory. For example, you may have defined your normal range for ups and downs as between +2 and -2, and identified that at +6 you are hypomanic and at -6 you are bordering on an episode of depression. In that case, the points at which you may need to take action are probably +3/4 and -3/4. The first level of action may simply be to increase your self-monitoring and reduce any stressors. By +4/5 or -4/5 you may need to intervene more actively, for example, changing an unhelpful situation or recording and challenging your own unhelpful thoughts.

Noting action points may enable you to intervene early enough to prevent your normal mood variations developing into more major mood swings. The intensity of the action you need to take will obviously depend on how severe your symptoms are, or how much your daily functioning is impaired. If you think you may be unable to take action on your own, it may be useful to share the information in advance with other people who may be able to help you. We will discuss the content of your action plan later in this book.

Lastly, mood charts can also be used to monitor responses to changes in treatment or circumstances. These graphs are more reliable than simply trying to recall how you have been over an extended period of time, and again provide evidence rather than impressions about your progress. A blank copy of a mood chart is provided in the Appendix on p. 230.

Monitoring Your Activity Levels

Many individuals report difficulty in developing their awareness of mood shifts, and find that monitoring their activity or energy level is a more sensitive measure of their mental state. For example, they note that they become overactive in the early stages of a “high” or underactive when they feel “low”. Others find monitoring activity levels is a powerful tool for stabilizing their day-to-day mood.

Assessing one’s daily and weekly activity schedule is a technique used in many time-management courses. The added value of using this approach if you experience a mood disorder is that you can also explore the links between activities, thoughts, and emotions. Activity scheduling is widely used in CBT for depression, but its use in individuals with mood swings often needs modification to ensure that the changes in activity that help overcome depression do not lead the individual into an upswing.

Activity Scheduling

At its most basic, an activity schedule is a written record of how you have spent each hour of your day. Simple as this may seem, the information recorded can further develop your understanding of how your mood changes in response to how you spend your time, or how your current mood influences your activities and the way you behave.

To construct an activity schedule you need to draw out a blank timetable to cover 24 hours a day for every day of the week. Dividing your waking time into hourly or two-hour slots works quite well and usually allows enough space to record key activities. Obviously, you don’t need as much space to record events during the night, so only allocate a few boxes to the time between going to bed and getting up. Over the course of a week, keep a brief note of what you actually did in each period of each day. Next add two ratings to each activity: a P rating to show how much pleasure or enjoyment you got from each activity, and an A rating to record what sense of achievement you got from undertaking that activity. As with the mood chart, use a 0 to 10 (or 0 to 100) rating scale, where zero means “no pleasure” or “no sense of achievement”, while the top rating on each scale represents a very pleasurable activity or a great sense of achievement. Sometimes the P and A ratings will be similar (e.g. when you feel pleased with yourself after doing something that you

found difficult, such as giving a talk to a group of people). But at other times the ratings will be quite different (e.g. taking a relaxing bath may be very pleasurable, but may not give you any sense of achievement; while clearing rubbish out of the garage may give you a great sense of achievement, but may not be very enjoyable).

When undertaking activity scheduling it is important to use your *current* level of functioning as the standard for the P and A ratings. For example, going out to meet a friend may not seem much of an achievement when you are your normal self. However, when you are depressed this may take considerable effort on your part and should be rated accordingly. Also, it is helpful to try to apply the P and A ratings as soon as possible after the activity, so you are gauging your immediate response. This approach ensures that the record is an accurate reflection of your situation. If you carry the schedule around with you, it will only take a moment to make these notes. An example of an activity schedule is shown in Figure 8. A blank schedule is also included in the Appendix on p. 231.

Figure 8 Jane’s Activity Schedule

TIME	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
12 midnight to 6a.m.						Didn't sleep stayed up listening	
6 - 8a.m.						to music P=9, A=5	
8 - 10a.m.	College	College	College	Skipped college and went			
10a.m. - midday	College P=5, A=7	College P=6, A=6	College P=7, A=5	shopping with	Got up late , so missed		
midday - 2p.m.	Food shopping P=5, A=5	Bought Joe a birthday present P=7, A=6	Visited neighbour for coffee P=7, A=6	Jane and Sue P=5, A=7	college P=4, A=2		
2 - 4p.m.	Tidied house P=6, A=7	Tidied my study P=8, A=9	Went to bank to sort my grant out P=4, A=8	Late lunch with Jane, Sue and Michael P=7, A=5	Lunch and drinks with		
4 - 6p.m.	Went to launderette P=4, A=4	Afternoon nap P=7, A=3	Visited college library	Early trip to cinema P=7, A=6	Joe and May P=8, A=6		
6 - 8p.m.	Evening in watching TV P=5, A=4	Evening watching favourite series on TV P=8, A=4	To get references for essay P=6, A=8	Night out with bowling club - drinks followed by			
8 - 10p.m.	Bed at 10p.m. P=6, A=2	Bed at 10p.m. P=7, A=2	Wrote a few notes for my essay P=6, A=7	Disco till the	Disco in town till after midnight		
10 - midnight			Gave up and went to bed at 11p.m. Watched TV for an hour P=7, A=3	early hours P=9, A=5	P=10, A=6		
MOOD CHART RATING	+2	+4	+5	+6	+6	+7	

When you have been monitoring your activities for about 14 days, look back over your schedule and examine the range and pattern of your activities, and try to pinpoint those activities that you most enjoy, or those that give you the greatest sense of achievement. As the pleasure rating is also a measure of one aspect of your emotional state, you may also be able to establish links between your activity levels and your moods.

To help you think about how to assess the information you have gathered, take another look at Figure 8 and then try to answer the following questions:

- What is Jane's *general level of activity* – very demanding, appropriate, low? (How full is each day?)
- What is her *pattern of activity* – very regular, mixed, disorganized? (How does the activity in one day compare with the next?)
- What type of activities does Jane *enjoy*? (What are her P ratings?)
- What sort of activities give her a *sense of achievement*? (What are her A ratings?)
- What do you notice about Jane's *sleep pattern*? (Check times of getting up and going to bed.)
- Is Jane's sleep pattern associated with any general changes in her *mood state*? (Check mood chart ratings included at bottom of activity table.)

You may now like to apply the same questions to your own schedule, adding the following three extra questions:

- Is the schedule for the time period you are looking at typical of your day-to-day life? If it is not, you may wish to repeat this exercise when you are involved in your usual routine.
- If this is a typical schedule, do you have a regular pattern of sleep, do you eat at regular times, and are there any regular patterns to your social activities? This will provide a basis for the exploration of social rhythms that will be discussed shortly.
- How do the ratings on your schedule compare with your ratings on your mood graph?

This last question is particularly useful if you experience both highs and lows, as in some circumstances it may help you to become more aware of how and when your mood swings become a problem. Let's look at Jane's schedule and her mood chart to explore how this might be done. If you look at the pattern of activity on the Wednesday, you will see that Jane engaged in a number of activities she enjoyed, and her mood chart reflected that she was definitely feeling in a positive frame of mind. On the Thursday, Jane did lots of activities with friends, and was out socializing and drinking alcohol late into the night. By the end of the week her positive mood state was approaching a level where she needed to take action.

While we do not know just from looking at the charts whether Jane's increased activity was a cause or an effect of her starting to go "high", you can see that the activity schedule may give clues about activities that are "overstimulating" or high risk. Some individuals find it helpful to monitor activities S (stimulating) or HR (high risk) and again to measure the degree of S or HR on a 0 to 10 (or 0 to 100) rating scale. If you are not sure if an activity is overstimulating, you could try the following exercise:

- Briefly describe the actual activity.
- Write down your mood and energy (or activation) levels immediately before engaging in the activity.
- Re-rate your mood and energy levels immediately after the activity.

As with P and A ratings, the ratings for mood and for energy or activation may differ.

Some individuals report that stimulating activities are more likely to push them into the “danger zone” where a high may begin than simply engaging in lots of activities that they enjoy doing. Undertaking this type of rating may help you to see if you are vulnerable to highs if you repeatedly engage in stimulating activities. An example is given in Box 4.

Box 4 Monitoring activities to evaluate if they may be too stimulating		
Actual activity	Mood and energy <i>before</i>	Mood and energy <i>after</i>
Swimming	Mood = +4 Energy = +5	Mood = +4 Energy = +3
Meeting at social club; dance with four other friends	Mood = +4 Energy = +5	Mood = +5 Energy = +8
<i>Ratings: mood –10 to +10; energy level 0 to +10.</i>		

Self-Regulation

Having developed your self-monitoring skills, the next step is to modify some of your activities to try to help stabilize your mood and reduce the risk of more extreme swings. The intervention used to promote stabilization is called *self-regulation*. The idea behind this approach is that more regular patterns of behavior seem to help stabilize circadian rhythms and reduce the likelihood of unpredictable shifts in mood and activity levels. To apply self-regulation to your own life, you need to select events that occur on a daily or weekly basis and try to develop a regular pattern to them.

Some individuals find that self-regulation on its own helps them feel more settled and better able to cope with their moods. However, others will need to extend their efforts to examining and then modifying their thinking. We will move on to these areas in Part Three of this book.

Using Your Activity Schedule

Initially, you have used your weekly activity schedules to monitor your daily activities, and your mood and achievement ratings. As we found for Jane, you may have been able to identify aspects of your own schedules that improve or worsen your mood over a day or a week. In order to begin self-regulation, we need to examine a series of your activity schedules. This will enable you to understand your pattern of activities and to assess the impact of any changes that you make.

Start by laying three or four schedules out in front of you. As you glance through them, ask yourself the following questions:

- Do you think that your schedule is reasonably balanced?
- Is it very demanding or very empty?
- Are your activities organized or disorganized?
- Are your activities both demanding and disorganized?

Disorganized schedules with no regular patterns of activity are indicative of irregular social rhythms and may lead to circadian rhythm disruption. Likewise, demanding schedules may lead you to feel stressed or overstimulated, either of which can trigger an episode of mood disorder.

If you are not sure how balanced or regular your schedules are, you may like to read the following paragraphs and then review your schedules.

Demanding schedules:

Problem: A demanding schedule can be defined as one that includes more than four significant events or activities on most days of the week, particularly if there is no regular pattern to the activities. Note that a pleasurable activity, such as lunch with a group of friends, counts as a major activity!

Possible intervention: If you do seem to have a lot of busy and demanding days, it is worth reviewing whether you can make some changes. For example, can you adopt a slightly slower pace and spread out potentially stimulating activities over a longer period of time? Also, can you include more calming activities in your schedule, or increase the number of activities that you do alone? This is particularly helpful if you find being with friends very stimulating. You could also consider seeing fewer friends at one time, perhaps just one or two together, as a larger group is likely to be more activating. Again the byword is *balance* – friends may help lift your mood when you are down, so I am not suggesting you avoid this important source of reinforcement altogether. However, too much activity and too many social engagements will not benefit someone at risk of an upswing.

Disorganized schedules

Problem: Common signs of a disorganized schedule are a large number of unfinished activities and the lack of any regular pattern to your days. You may also have relatively few high A ratings, suggesting that you don't often feel a great sense of achievement. In looking over your schedule, note how regular your daily routines are. For example, what time do you eat each meal, and on how many days do you eat three meals? How often and at what time do you get exercise or meet with other people? What time do you go to bed or get up, and how many hours do you sleep each night? It is also worth noting whether you do any or all of these activities on your own or with other people.

Possible intervention: The first intervention to make if you have a disorganized schedule is to try to develop regular times for getting up and going to bed, for eating meals and meeting people, and having periods of relaxation. If you can establish such routines, you will then probably find it easier to decide which other activities or tasks you wish to include in your schedule, and how much time you can allocate to each additional task.

Disorganized or overdemanding schedules are common, but even if your schedule

does not fit with these descriptions, there are three key components to self-regulation that you may find helpful:

Regular routines and forward planning Many people find it helpful to plan their schedule for each day beforehand. I usually encourage individuals to sit down in the evening and plan the whole of the next day to ensure that they are not trying to fit too much (or too little) into their schedule. Given that stable patterns of activity reduce the risk of circadian rhythm disruption, it is worth introducing predictable routines for frequently recurring activities, such as mealtimes etc. Do not despair at this thought; no one is trying to remove the fun and spontaneity from your day-to-day life, but you will benefit from some stability in your basic activities.

To gauge how well you are managing this approach, you may wish to keep a record charting your regular activities – this will give you instant feedback. The graph is similar to a mood chart, but this time you put the hours of the day along the vertical axis. Your first aim is regularly to eat three meals a day and to keep the time of each meal to within about an hour (e.g. lunch between midday and 1 o'clock). Your second aim is to try to develop regular habits around sleep. Again, you should aim to go to bed, or to get up, within a band of about an hour; but it is not the exact time you retire to bed or get up that is critical. The two most important elements of a regular sleep pattern are trying to go to bed at about the same time each night and regularly getting the amount of sleep that you need.

A self-regulation chart showing a week's record of sleeping and mealtime patterns is shown in Figure 9.

If you have difficulty in limiting the number of activities you plan to do, you may need to learn to prioritize. First write a list of all the activities and tasks you believe you need to complete in the coming week, followed by the deadline by which each needs to be completed. Can any of these tasks be put off, or can anyone else take responsibility for their completion? Please try not to give yourself a hard time if you ask others to help. Your mental well-being is more important than trying to prove you can cope better than someone else or that you can do the impossible. Retaining responsibility for a task, becoming stressed, and then spiralling into a mood swing will not benefit anyone, least of all you.

Figure 9 A self-regulation chart: monitoring routine activities

Activity	Preferred Time (in bold)	Rating of Actual Time Did the Activity
		M T W Th Fr Sa Sun
Getting Up	6am	
	8am	
	10am	
Breakfast	7am	
	9am	
	11am	
Lunch	11.30am	
	1pm	
	2.30pm	
Quiet Time	3pm	
	5pm	
	7pm	
Supper	6pm	
	7.30pm	
	9pm	
Going to Bed	9pm	
	11pm	
	1am	

Having reduced the list as much as possible, try to identify all the high-priority tasks, then the medium-priority, then the low-priority. Next organize an “A” list of all your high-priority tasks, written in order of how important it is to complete each task. Then spread them out across the days of the week in order of priority. You should *not* aim to include more than one or occasionally two high-priority tasks in each day. Also, remember not to make the rest of each day too busy – particularly if you have important tasks to undertake on most days of that week. The activities that you

identified as medium or low priority should now be written on a “B” list; and you should only go back to these activities *after* you have dealt with your high-priority tasks for that day. Remember, if they are really important they will make it to your “A” list within a week or so. If they don’t make it to your “A” list, you may be able to remove them from your priority list altogether. An example of “A” and “B” lists is given in Box 5.

Forward planning and priority lists are useful whether you are at risk of downswing or upswing. Those who are depressed find that they help to reduce procrastination and fend off hopelessness. Writing a note each evening means that when they get up in the morning they have a sense of what they are going to try to do in the day ahead. Also, they can plan to include within their schedule activities that they usually enjoy, to try to lift their mood as much as possible. This tends to reduce their anxiety and help them get started each day.

On the other hand, those who are worried about going “high” often find that they can retain greater control if they have a plan of what they are trying to achieve and can structure their day so that they are not easily distracted or don’t try to cram in more and more activities. If you are bordering on going high, it is also valuable to do two things. First, show your plan to someone else, to get feedback on whether it is sensible or overambitious. Second, plan your day and stick with your plan: do not add activities because you feel good.

With practice, you can start to plan your schedule for a week in advance. There are many advantages to this longer-term planning. For instance, you can develop a list of things you want to do during that week and ensure that they are spaced out over the seven days. This is especially important for those activities that you enjoy or those that you find overstimulating, which you can spread out to ensure that you get the maximum benefit and the minimum disruption from them. It is also a good way of monitoring the regularity of your basic activities, such as eating, sleeping, and exercise or relaxation routines. With time, you will hopefully develop a more realistic approach to what you can or cannot do in the time available.

Box 5 A and B lists	
<p><i>Activities and tasks to do:</i></p> <p>Pay the rent</p> <p>Go to the housing association weekly coffee morning</p> <p>Take kids to swimming lesson</p> <p>Visit doctor to have blood test</p> <p>Fetch copy of next month's theatre programme</p> <p>Make an appointment for a dental check (due in three months)</p> <p>Wash the car</p>	<p><i>A list:</i></p> <p>Pay rent</p> <p>Go to doctor</p> <p>Take kids to swimming</p> <p><i>B list:</i></p> <p>Housing association (go next week)</p> <p>Fetch copy of theatre programme (delay this – I've got to go past the theatre next Thursday anyway)</p> <p>Dental appointment (not urgent)</p> <p>Wash car (ask Jack)</p>

Stable activities = *stable mood* Having established more regular routines and social rhythms, the next step is to develop a balanced programme of daily activities. To attain balance you will need to make a regular assessment of the activities in your schedule. There are three key areas to consider:

- *Your overall level of activity:* In judging whether your overall activity level is appropriate, try to assess the quality as well as the quantity of the activities you engage in. Quality is probably more important than quantity, and more rewarding in terms of both pleasure and sense of achievement.
- *Appropriate activities for different mood states:* When you are feeling elated or possibly going high, you may need to increase the number of calming activities that you include in your schedule. When you are depressed, on the other hand, you

will need to add activities that you enjoy or that can help lift your mood.

- *The balance between solo and joint activities:* It is important to try to include a mixture of activities that you do alone and activities that you do with others. Again, your mood state may dictate when it is better to pursue a higher level of interaction (when you are down) or a lower level of interaction (to avoiding overstimulation when “up”). These aspects will be considered further in a moment.

It is useful to review your planned schedule at the end of each day and see if you managed to complete all the tasks you had listed for it. This will allow you to decide if you are still putting too much or too little into your schedule. If you do not complete the tasks you set yourself, ask yourself what the obstacles were. Did problems arise that interrupted your schedule? If so, how predictable or unpredictable were these difficulties? Or did you simply underestimate the amount of time you needed to complete various activities? By answering these questions carefully, you can progress toward a realistic activity schedule that incorporates both the basic day-to-day tasks that you need to complete and the pleasurable activities that you want to include.

Trial and error It may take some time to identify a balanced and realistic activity schedule that has regular social routines, but still allows you to feel you have control over your own life. Self-regulation does require an element of self-discipline, and you would not be human if you did not stray from your planned schedule from time to time. Also, it will take a while to determine the right mix of activities for you and to be sure about which activities genuinely help you improve your mood state.

The best way to cope with these uncertainties is to view the whole process as an experiment. Try out different schedules, and keep notes on which you prefer and which give you the most stability in your mood and functioning. Most importantly, don't judge your new, more regular schedule too soon. It will usually take a minimum of two to three weeks to feel comfortable with your new routines, particularly if you are attempting to reduce the level of activity and stimulation in your day.

Additional Approaches to Effective Self-Regulation

There are several other aspects to effective self-regulation as well as activity scheduling. The main ones are:

- diet and exercise;
- stimulus control;
- relaxation; and
- sleep routines.

Some general information and advice on each is offered here to help you work on these areas.

Diet and exercise No one can tell you how to lead your life. However, if you have mood swings that cause you significant problems, there may be some modifications to your lifestyle that are worth considering. It is well recognized that physical illness

can put your body under stress and precipitate mood swings in individuals who are at risk; for this reason alone, it is worth paying attention to your general health. This may start with scheduling three regular meals each day as part of a process of stabilizing social routines, as discussed above. You could extend this effort by trying to improve your diet and adding in some regular exercise. You might begin by making a commitment to exclude junk food from your diet. There is no evidence that “E factors” or food additives directly affect the frequency or severity of mood swings, but they may have some effect on some people; so reducing your intake of these substances is a reasonable choice to make. If you are not sure whether such dietary changes will be of any benefit to you, you can always monitor the effects of including or excluding these foods on your mood and level of activation. In addition, you can judge whether changing your eating habits helps you to gain or lose any weight.

Even if you are not keen on exercise, perhaps you could try walking for about 15 minutes every other day. An hour a week of moderate cardiovascular exercise – just enough effort to make your heart and lungs work a little harder – can be helpful to your general fitness. Furthermore, exercise has a positive benefit on your mood and is known to be effective in reducing mild symptoms of depression. As you become fitter, you could consider a greater commitment to an exercise programme, perhaps joining a regular group at, say, aerobics, or going jogging.

If these changes to diet and exercise are difficult to pursue alone, it is always worth trying to find someone else who also wants to eat a healthy diet or take more exercise. That way you can encourage each other to stick with your plan.

Stimulants and stimulus control Before discussing substances that contain stimulants, I would like to comment briefly on some other aspects of stimulus control. In the preceding pages, I have indicated on several occasions that there may be disadvantages to meeting with large groups of friends if you are at risk of going into a “high”. Individuals who only ever experience downswings are often encouraged to seek the company of others; however, those who suffer highs as well as lows have to be more cautious, as at certain times they may find social situations overstimulating. Other activities, too, can be equally “high risk” when on the edge of an upswing. Taking part in exciting activities that incorporate an element of risk, like rollercoaster rides or go-kart racing, may be a trigger as well as a symptom of going high. Sometimes visiting the cinema to see a thriller or action movie may start to push you further toward a high; lively music can have the same effect. There are no set criteria by which to judge in advance what you will find overstimulating, but it is important to be aware of such possibilities. As discussed on p. 94, generating a list of these activities and avoiding them when you are at risk of a high, is a sensible approach.

As part of your efforts to lead a more healthy life, you may decide to cut down on your caffeine and nicotine intake. Caffeine is found in coffee, tea, and many soft drinks. Cutting down on soft drinks may also reduce your intake of sugar and other food additives. The main reason for encouraging you to reduce your intake of all of these substances is to allow you to understand your body’s “baseline state” – that is, how it feels and functions before you take in any substance that may affect it. If you wish to understand the effects of life events, behavior, and medication on your mood swings, you need to be able to make these judgments without other factors clouding the issue. It is not easy to cut down on nicotine and caffeine, but a gradual reduction

will help you make important and accurate assessments of how you are feeling. For example, knowing the difference between feeling “edgy” because you are starting to go high and feeling like this because you have too much caffeine or nicotine in your system is important if you are trying to decide what action you need to take. Likewise, symptoms of caffeine withdrawal may feel like the early stages of becoming depressed.

Alcohol and illicit drugs also have powerful effects on your mood and energy levels. The more you can reduce your intake of these substances the better. Even if you know someone with mood swings who has tried these substances without adverse effects, there is no guarantee that you can try them yourself with any safety. Some individuals feel that using these substances helps them treat their own symptoms, but the reality is that all of these substances can destabilize your physical and emotional state and push you into a severe mood swing or an episode of depression or mania. There is no getting away from the fact that the use of alcohol and drugs represents high risk; if possible, if you do use these substances, you need to have a plan for harm reduction.

Harm reduction involves two key elements. First, you must tell the doctor or clinician what you use, and how much. They may be able to help you reduce your intake. Even if you don’t want that help at present, telling your doctor what’s going on means they can avoid prescribing medication that might interact with these substances. Such interactions can have very unpleasant and serious physical consequences, so the least you can do is to protect yourself against these problems. The second element of harm reduction is to consider whether you can cope without alcohol or drugs, or at least reduce your intake. If you do wish to cut down, you will first need to assess your use (e.g. by recording how much and how often you use the substances on your activity schedule, or in a diary). The recommended highest levels of alcohol intake each week are 22 units for women and 28 units for men. (Some recent studies suggest these levels should be reduced to 14 units and 21 units respectively.) One unit of alcohol is equivalent to a single measure of spirits, a glass of wine, or half a pint of lager or beer.

The next step is to assess what action you can take as part of a personalized “harm reduction” programme. It is usually easier to reduce intake of alcohol or drugs gradually rather than stopping suddenly. In addition, gaining the support of other people will probably help you, particularly when you feel stressed or are finding it hard to keep your “harm reduction” programme going. It is unlikely that this programme of reduction will proceed without any hitches, so it is important not to give up and view your attempt as a failure simply because you hit difficult times. Try to plan one day at a time, and keep reminding yourself of the positive benefits of trying to control your use of these substances. A similar harm reduction approach may also help individuals who are “addicted” to gambling.

Learning to relax In order to reduce the risk of feeling stressed or high, it is helpful to learn about and regularly use relaxation techniques. There are many different methods of relaxation, and you may well need to try a number of approaches before you find the one that suits you best. Having found a suitable technique, it is a good idea to do it regularly so that you are familiar enough with it to employ it even when you are feeling stressed.

You may not realize that exercise, such as a 30–40-minute stroll or even a physical

workout, can be used as a relaxation technique. Some people prefer these active approaches, as opposed to the more generally accepted muscle relaxation or controlled breathing exercises. Others find that gripping and releasing stress balls, playing relaxing music, or receiving a massage is helpful. Relaxation tapes, learning to meditate, or using methods described in books on relaxation are also recommended. Three simple techniques are described here:

- *Ten by ten*: This technique uses word repetition and can be helpful if you simply need to distract yourself from a particular thought that is preoccupying your mind. Take a positive word such as “calm” or “relax”. Repeat it to yourself ten times. Do this slowly without allowing other thoughts or ideas to intervene. Repeat this exercise ten times during the day, or every hour if you are feeling stressed.
- *Controlled breathing*: Some people prefer to use the controlled breathing technique when lying down. However, if you feel tense in a crowded place, you could try to find a quiet space and simply stand still and focus on your breathing. Stand straight upright with your shoulders relaxed. Breathe in deeply and slowly through your nose over about four seconds. Pause after taking this breath and imagine oxygen reaching the extremities of your body, your toes and your fingers. Slowly and gently breathe out through your mouth for about the same length of time. Continue to stand tall and to breathe slowly in and out. Allow your mind to clear. If this is difficult, imagine yourself in a pleasant, quiet place, e.g. lying in a hammock on a beach. Continue the exercise for a few minutes until you feel calm and relaxed. This usually takes three or four minutes.
- *Progressive muscular relaxation*: This exercise involves tensing and relaxing groups of muscles in your body. Some people like to develop a set sequence of muscle relaxation starting with the toes, but again personal choice is important and it is worth experimenting with what works best for you.

Begin by tensing one particular set of muscles, e.g. the foot muscles. Contract the muscles for about five seconds, then relax over about ten seconds. Dwell on the feelings as the muscles relax and imagine a positive warm glow spreading up your leg and into your body. Repeat this with the next muscle group until all the muscles of the body have been contracted and relaxed.

These three techniques are relatively easy to follow and usually begin to take effect quite quickly. You may prefer one approach over the others, or you may find that you like to use different techniques at different times. The most important element is confidence. Becoming familiar with a technique and knowing it works is more important than which particular technique you choose.

Sleep routines There is no such thing as an ideal amount of sleep – people vary in the length of sleep they need. What is important if you have mood swings is developing a stable routine, because sleep disruption may trigger or follow on from mood shifts. The key to a healthy sleep pattern is to try to develop a regular and foolproof system for when you go to sleep and when you get up. This system will never be perfect, particularly as mood disorders are often accompanied by sleep disorder; but the more stable your sleep routine is, the easier it will be for you to deal with these periods of disruption.

The first aim is to try to settle into a regular time of going to bed. When you have established a time that is reasonable for you (probably between 10 p.m. and 12

midnight), you need to review how you spend the preceding hour or so before you go to bed. This is known as the “winding down” time. The key things to avoid are too much eating or drinking (particularly avoiding alcohol or caffeine), too much loud music, and too much stimulation – including watching exciting television programmes. If you need activity, try listening to soothing music, taking a gentle stroll, or perhaps a relaxing bath. If you like a drink at bedtime, make it a warm, milky one. Try to ensure your bedroom or sleeping area is conducive to sleep. Is the bed comfortable, is the room temperature to your liking, is the lighting low enough, and is the space quiet enough? Next, try to use simple relaxation techniques to help you get off to sleep. Some people like to read or watch television, but it is worth trying a few experiments to determine whether these approaches increase or decrease the length of time it takes you to fall asleep once you are in bed.

Next, assuming you have managed to get off to sleep and have slept through the night, try to get up at a regular time. To start this process, set an alarm clock for the same time each day, *including* weekends. Even if you are tired, try to stick with this routine. To ensure that you sleep well at night, it is best to avoid taking naps during the daytime. Even if you have a poor night’s sleep, dropping off during the day tends to lead to a further poor night of sleep.

Most people who follow these basic guidelines usually find they help overcome the common problems in getting off to sleep. However, some people find that when they get into bed their mind becomes filled with negative thoughts, or they wake up before dawn and don’t know how to cope in the early hours of the morning. If this happens to you, the following simple tips may help; if they don’t, you may wish to consult a specialist book on sleep, or talk to a doctor or clinician.

If your mind is full of *anxious or negative thoughts*, you can try:

- distracting yourself by imagining pleasant and relaxing scenes;
- writing your concerns in a notebook and planning to review them in the morning;
- imagine placing all these concerns in a “worry truck” and sending the truck to a garage that does not open until after you get up the next morning.

Try to avoid drinking alcohol; although small amounts may initially sedate you, alcohol disrupts sleep patterns and will probably make you wake up more during the night.

If you *wake early*, the advice is different depending on whether you are feeling positive or negative about yourself and your situation.

If you are feeling slightly high and your mind is full of bright ideas, it is actually better to try to stay in bed and relax until it is time to get up. If you must do something, you could make a simple note of your ideas *for a maximum of two minutes*, then try to use relaxation and distraction techniques that calm you down. Try to stick with your self-regulation programme, as too much stimulation too early in the day may increase the risk of going high.

If you wake up and feel very depressed and negative, you can try to relax or to distract yourself and see if you can rest. If this does not make you feel any better, it may help to get up and do something active. If this pattern of early waking occurs regularly when you are depressed, it is good to plan for this situation ahead of time by designing a schedule of things you can do on your own when there is no one else awake. This might include simple tasks in your home that keep you occupied; other

options are reading books, playing music that you enjoy and that may lift your spirits, or watching a video that you like. It is also worth having the telephone numbers of people you can contact at such times if you cannot shake off your feelings of unhappiness.

If none of the above strategies works, it is worth consulting your doctor about what else you can try, and/or whether a short course of sleeping tablets is required to get your sleep pattern back on track.

Planning for change Self-regulation is easier to maintain when you are in a stable environment, but many individuals experience changes or disruptions in their routine. These changes are often planned and viewed as positive, for example, when they involve visiting people you like or travelling to new places. However, if you are at risk of significant mood swings you do need to plan ahead to make sure that the inevitable changes in your routine do not threaten your well-being. One simple precaution you can take is to avoid travelling at night if at all possible. This will reduce the risk of sleep disruption. If night travel is the only option, it is sensible to avoid alcohol or caffeine and to try to sleep during your journey. If your trip involves a significant shift in time zones, you may wish to consult a doctor or clinician in advance about how to adapt to your new situation.

Even when you find yourself in a new situation it is worth trying to retain key elements of your self-regulation routine such as sleep-wake times, mealtimes, exercise, and quiet time or opportunities for engaging in relaxation techniques. The main principle is to enjoy your new situation and experiences while at the same time avoiding dramatic changes to your usual routines. Don't make rigid plans that stifle the opportunities to have fun, but don't throw away everything you've gained from self-regulation for the sake of a few days or a few weeks of doing something different. There is a temptation to take a break from activity scheduling when going on vacation, but it is actually quite a good idea to do some forward planning for your holiday itinerary and to keep a record of what you actually did each day. In the end this only takes a few moments out of the day but it allows you to gauge how you are coping and whether you need to modify your planned schedule.

Summary

Self-management involves two key elements: *self-monitoring* and *self-regulation*.

Self-monitoring involves:

- mood charts
 - developing a *mood graph* that charts changes in two key mood states;
 - carefully monitoring changes in mood, thinking, and behavior against defined “*anchor points*”;
 - identifying “*action points*” where early intervention may avert major problems;
- activity schedules:
 - monitoring and recording day-to-day activity on a *weekly timetable*;
 - *rating pleasure and achievement* for each activity;
 - *reducing high-risk (HR) or over-stimulating (S) activities*.
- Self-monitoring also includes understanding the links between mood and behavior.

Self-regulation involves:

- using activity schedules to develop *regular patterns* for sleeping, eating, exercise, social activities, and calming activities or relaxation;

- reducing excessive demands on your time and *improving the organization or predictability* in your daily activities;
- planning a *realistic and balanced approach* to your day-to-day life that retains positive experiences, but reduces the potentially negative effects of chaotic schedules and excess use of alcohol or stimulants.

Self-regulation also demonstrates how mood, what you do, and physical state are linked.

Self-regulation may stabilize mood and activity levels and reduce the risk of minor mood shifts escalating into major mood disorders.

Biting the Bullet: Sticking with Your Medication

Part One of this book discussed the use of medication in the management of mood disorders, and we noted that mood stabilizers are a mainstay in the treatment of bipolar disorders. However, about half of all the people prescribed these medications stop taking them at least once, against medical advice, and many others express ambivalence about taking tablets. In my experience, the decision about whether or not to take long-term medication causes considerable difficulty to many individuals. They struggle particularly with the sense that as medication is being used to stabilize their mood they are deprived of control over their own lives. In recognition of the problems experienced by many in coming to terms with medication, I have called this chapter “Biting the Bullet”.

If you are currently being prescribed medication but are not sure if this chapter is relevant to you, try answering these two questions:

- Do you ever have difficulty taking your medication as prescribed?
- Do you ever try to cope on your own without taking your medication?

If you have answered yes to either of these questions, you have clearly (intentionally or unintentionally) omitted some of your medication at some time. You may therefore find it useful to look at why others do not take their medication, and explore simple ways to try to get the best from your own treatment.

Why Don't People Take Their Medication?

There are many different patterns of adherence to medication. Some individuals take everything they are prescribed in a regular manner; others regularly miss out part of the total dose; others show “cycles of adherence”, taking the treatment regularly over many months when they feel ill, but becoming less strict when they are feeling better; some individuals take none of the prescribed medications. Interestingly, research suggests that both total adherence and total non-adherence are rarer than some form of partial adherence. The reasons given by individuals for *not* taking some or all of their medication fall into three broad categories, which I will now look at in turn.

Treatment Regime

A common barrier to medication adherence is lack of knowledge about the treatment. For example, many people do not realize that they need to continue with the prescribed medication even after they have stopped having symptoms. Other problems are a complicated treatment regime and medication side-effects. (I have included a table of common and more serious side-effects in the Appendix, p. 233). It is interesting to note that research suggests many individuals are prepared to tolerate minor side-effects if they believe the benefits of treatment outweigh the negatives.

Lifestyle

This is essentially a question of how chaotic or organized a person's daily routines are. A person with a chaotic lifestyle may not have developed a regular pattern of taking medication as part of their daily schedule, or may regard the whole process as a hassle. Without some sort of "cue" to remind them, they often forget to take their medication.

Attitudes and Beliefs

Many of the people who report not taking their medication give as a reason their belief that the treatment will not help or that the medication prescribed is not the right approach. Some believe that the threat posed by their mood disorder (their susceptibility to relapse, and the likely severity or consequences of an episode) is less than that posed by treatment. In particular, individuals with mood disorders report that they dislike taking mood stabilizers because they do not wish to be reminded of their long-term problem on a daily basis, and do not like the idea of medication being used to control their mood. Others report that they have a negative attitude toward any prescribed treatment for any health problems, and always prefer to try to cope without medication. In yet other cases a relative or friend influences the person's attitude toward the prescribed medication.

The influences of all these factors on medication adherence can be combined as shown in Figure 10.

Self-Management of Adherence

The interventions that you can use to improve your own medication adherence follow logically from the description of the key reasons, outlined above, as to why people do not take their prescribed medication. The approaches also try to target all the elements of the model shown in Figure 10.

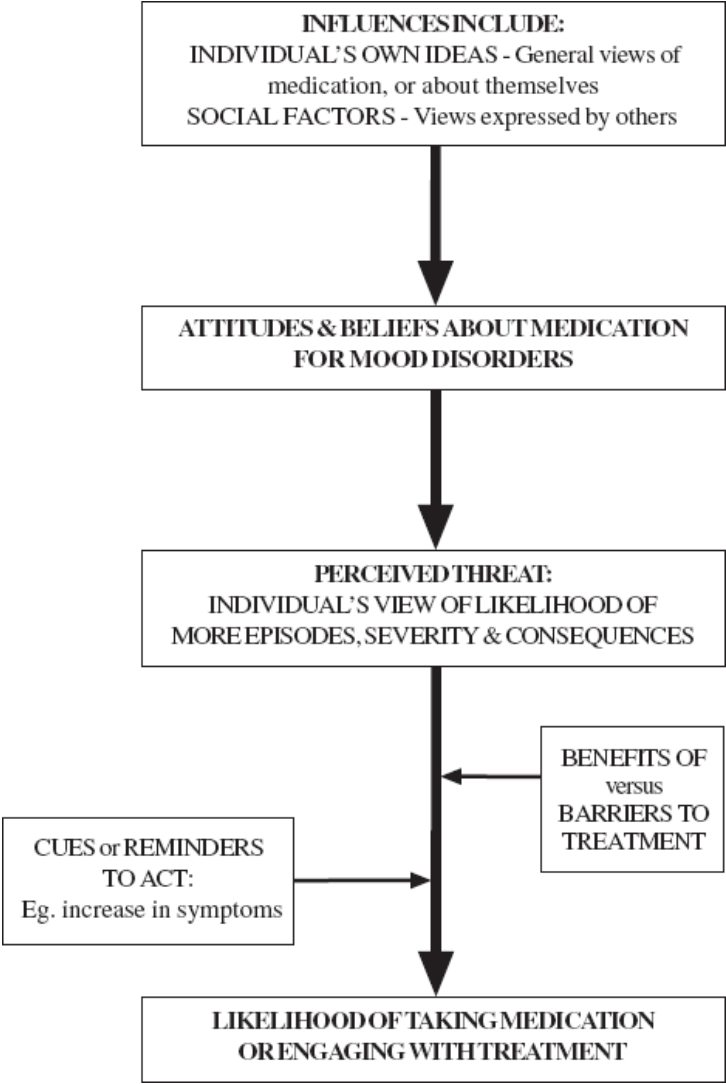
Knowledge

If you are not clear about what treatment you are being offered, how often you should take it, or other aspects of the regime, it is hardly surprising that you are at high risk of not keeping up with your medication. The crucial questions are: Is the treatment regime understandable? Is it acceptable? Is it manageable?

Understandable Individuals are less likely to take the prescribed medication if the

information they have about the disorder and its treatment fails to fit together in a coherent manner. You need to check three issues to test whether the treatment you are being offered makes sense.

Figure 10 Factors influencing why someone might or might not take medication



- First, you need to record what you know about your current symptoms.
- Now record your own views about what these difficulties mean to you.
- Next compare these ideas with the advice and information you have from clinical consultations or other sources of information.

Do these three components (symptoms, meanings, information from others) fit together? If not, which aspect seems unclear or causes confusion? If you are finding it difficult to answer this question, you may like to work through the checklist provided in Box 6. Having the answers to these questions overcomes many basic problems related to adherence.

Box 6 A checklist of questions to ask about the disorder and its treatment
<ul style="list-style-type: none">• The diagnosis<ul style="list-style-type: none">What is the diagnosis and what does it mean for my future?• The prescribed medication<ul style="list-style-type: none">What is the name of the medication?What type of medication is it (e.g. mood stabilizer, anti-depressant)?What dose will I need, and will any blood test be required?Does it matter what time I take my medication?What should I do if I miss a dose of medication? Do I take a double dose or not?What common side-effects are there?What should I do if I get them?Are there any dietary restrictions, can I take other medications, and/or can I drink alcohol with this treatment?• Treatment benefits<ul style="list-style-type: none">Why do I need medication?How will each medication help me?How likely is it that I will respond to this medication? How soon should I feel better?How long will I need to stay on medication?How will I know if it is working?If the medication does not work how quickly can I stop taking it?Are there other treatments that could achieve the same benefits?

Acceptable The next issue is whether the medication regime is acceptable to you. Are there any side-effects that are so unacceptable that you need to discuss how to reduce them, or are there are different medications available that you might tolerate better? Alternatively, do you need evidence that the medications are safe in the long term before you feel happy to take them on a regular basis?

If any aspects of your treatment are not acceptable, it is important to try to resolve the difficulties identified in collaboration with your clinician. It will really benefit you if you take some responsibility for overcoming the issues identified and play an active and constructive role in this problem-solving process. The key aspects that you need to consider are:

- What specific problems make the regime unacceptable to you?
- What alternative approaches can you suggest to overcome any barriers identified?
- How can you work with the clinician to improve the acceptability of the treatment?
- How will you both know when the treatment becomes acceptable? What would be different?

Manageable Finally, you will find it easier to stick to the treatment prescribed if the regime is manageable. If it involves a number of medications, it is possible that you will have difficulty in remembering which treatment to take in what dose at what particular time of day. It is always worth asking whether the regime can be simplified so that it is easier to fit it in to your daily routines. Some people also find they can stick more closely with the prescribed treatments by keeping a written record of their

medication regime on a flash card (a piece of paper the size of a credit card) that they always carry with them. Others use a pill box or dosette which allows them to check whether or not they have taken each dose.

Behavioral Strategies

Overcoming any misconceptions about your treatment regime and correcting any unacceptable aspects helps many individuals. However, if you still find that your adherence to medication is erratic, you may wish to experiment with the following approaches.

Prompts You may be able to set up a simple system of reminders to help you stick with your medication regime. For example, you could lay your tablets out next to the alarm clock each night with a glass of water, or stick a note on the bathroom mirror reminding you to take your mood stabilizer when you get up, or set the alarm on your wristwatch for the time of your next dose.

Reinforcement If you share your home with others, can you ask someone else to remind you when to take your medication or to check that you have done so? Not everyone will wish to use this approach, some people preferring to keep control of the treatment. However, others report it actually benefits their relationships, as other family members are reassured that the medication regime is being followed and also feel they are making a small but helpful contribution.

Self-monitoring and self-regulation As discussed in the previous chapter, any regular activity can be incorporated into a daily schedule, and the time of day you take your medication is an obvious candidate for inclusion in your forward planning. In addition, if you know your activity schedule is going to change at some point, you can take the opportunity to rehearse what to do in advance. For example, Deborah's regular routine was to take her medication at breakfast (about 8.00 a.m.). However, when she enrolled on a training course, she knew she would have to leave home at 7.30 a.m. for most days in the next week. To cope, she decided to place the tablets next to her alarm clock and modify her routine for a couple of days in advance of the change in routine.

Another advantage of including medication adherence in your self-monitoring and self-regulation system is that you can identify and plan to cope with situations when you are at high risk of not taking your tablets. For example, Alex was a businessman who was away from home for two or three days most weeks. He noted that he frequently forgot to take a supply of mood stabilizers with him. It quickly became obvious that being away from home was a "high-risk situation" for non-adherence. With the help of his partner Alex instituted an "action plan". This simply required that they both checked his travel bag each week and made sure he kept a supply of mood stabilizers in it on all occasions.

Written treatment plans If these simple strategies are only partially successful you may prefer to take a more systematic approach to your adherence problem and draw up a treatment plan. This may include other aspects of treatment as well as medication adherence. Importantly, it also acknowledges the benefits of following this regime, the likely problems you will encounter, and the suggested methods for

overcoming these barriers.

When constructing your plan, try to be specific about the barriers you are encountering: then write down as many alternative ways of overcoming these problems as you can. From the list of potential solutions, you then need to assess how feasible it is for you to undertake each option and also how likely it is to work. Include the best two or three options on your treatment plan, and then monitor how helpful these approaches are over the next few weeks. Over a few months of experimenting with different strategies you should be able to overcome some if not all of the barriers. Box 7 shows an example of a treatment plan, and the Appendix contains a blank copy for you to complete yourself (p. 234).

Box 7 My treatment plan		
<i>My treatment plan is to:</i>		
<ul style="list-style-type: none">Take the following prescribed medication:		
<i>Name of medication</i>	<i>Dose</i>	<i>Frequency</i>
Fluoxetine	20mg	daily
Lithium carbonate	400mg	morning and evening
<ul style="list-style-type: none">Have contact with the following professionals:		
<i>Name of person</i>	<i>Frequency of contact</i>	
Dr Foster	every 8 weeks	
Janet (Community Worker)	every week	

<i>The benefits to me of this approach are:</i>		
<ul style="list-style-type: none">Medication helps me feel more stableBeing more stable allows me to plan aheadMedication keeps me out of hospitalHaving Janet to talk to really helps me solve my problems		

<i>The barriers to my sticking to this approach are:</i>		
<ul style="list-style-type: none">Several college friends, especially Morris, ask why I take medicationI keep forgetting to take the evening dose of lithiumIt's difficult getting to the community centre for appointments with JanetI worry the anti-depressant (fluoxetine) will send me high		

<i>The ways I might overcome these barriers are:</i>		
<ul style="list-style-type: none">I could read up on meds and try to explain things to Morris or give him the MDF leaflet on bipolar disorders if he's really interestedI'll start using a pill box and put a note by the mirror in my study to remind me about the evening lithium (?also ask if it is possible to take all the lithium in one go)I'll ask Janet if we can meet at the centre down the street as it's a lot easier for me to get to. She also does home visits, so perhaps that's an option.I will monitor for early warning signs of depression and ask Dr Foster at my next appointment about the use of fluoxetine		

Cognitive Strategies

If behavioral approaches do not help, it may be that your problems are more strongly linked with your views about mood disorders and the pros and cons of taking medication. Below are some ideas on interventions that may help you tackle these difficulties. Other techniques for tackling unhelpful thoughts are described in Chapter 9 of this book.

Examining the evidence To start to tackle your ambivalence towards medication you need to return to a common theme in this book: namely, being clear about the facts about your mood disorder, as opposed to your personal beliefs or the views of close family or friends. The particular facts to consider here relate to the threat to your well-being of rejecting the prescribed treatment. To do this, you could seek out information from any carefully conducted research on mood disorders (for example, from one of the sources at the top of the list on p. 80–81). From these reports, it is possible to draw clear conclusions about the likelihood of further episodes of mood disorder, and the likely severity of those episodes, in individuals who do or do not receive medication. Research suggests that individuals with a history of significant mood disorder experience more severe episodes more often if they do not take medication than is the case if they do take medication. If you fit into the group who are likely to do better with medication, the next – very critical – issue is trying to come to terms with these facts. Unfortunately, when faced with painful facts most human beings do one or more of the following:

- They ignore them or try to put them out of mind.
- They deny that their problems are the same as those described.
- They challenge the quality of the information.
- They argue that they are the exception.

If this pattern sounds familiar, it is because we discussed these mechanisms when looking at how our belief system affects how we view our world (see p. 40–50). But you have made a positive start: the very fact that you are reading this chapter of the book suggests that you accept you may have a problem. The next step is to agree the nature of the problem and how best to deal with it. The first step towards improving your adherence is to acknowledge that your negative attitudes or beliefs could be hampering your engagement with treatment. The next step is to try to help you suspend your negative attitudes and beliefs for long enough to test out some of the approaches to improving adherence. To start this process let us try two experiments.

First, a thought exercise: *What if the person you cared most about in the world had a mood disorder and came to you for advice about whether they should accept treatment? They have read up on the subject and have established the following facts:*

- *They have bipolar I disorder and have noted that this has a 95 per cent chance of recurring at some point in their life.*
- *They also belong to a group of individuals who are at risk of having severe episodes that have very negative consequences for them.*
- *The treatment available reduces the risk of further severe episodes by more than 50 per cent.*

If that person came to you for advice, what would you tell them to do? Are you absolutely certain you would tell them to try to handle the situation on their own and not to accept or even give a “trial” to the treatment offered?

This scenario is used simply to try to get you to check whether you are applying “double standards”. Are you expecting things of yourself that you wouldn’t expect of others? If so, are there any ways you can be kinder to yourself? For example, if you believe “I should try harder to cope with my mood swings,” trying harder can also be

“reframed” as “trying harder to stick with medication as well as using self-help techniques to cope with my mood swings”.

The other experiment involves checking the evidence that medication has never helped you.

- *First, take a close look at your life chart. Were periods of adherence associated with more or fewer episodes of mood disorder?*
- *Now look at your mood charts. Can you identify any additional stability or benefits offered by adherence to medication?*

If you are unsure whether medication has helped, or there is any evidence that medication has been beneficial, you may wish to try out some of the following approaches.

TICs and TOCs Some individuals say that they genuinely think they would like to stick with medication and frequently think about the benefits of treatment; unfortunately, they just can't bring themselves to take the tablets at the vital moment because at that point their thinking becomes flooded by reasons not to do it.

The thoughts that encourage adherence are called TOCs (task-orientating cognitions), while the thoughts that prevent engagement with treatment are called TICs (task-interfering cognitions). David Burns, a cognitive therapist in the USA, has described the use of TIC-TOCs to tackle a number of day to day problems.

Usually, TICs become more frequent as the moment when the medication is to be taken draws near, while TOCs are more common at other times. TICs are a form of negative automatic thought, and negative thoughts are more likely to occur when you are faced with a specific situation, such as taking medication. TOCs, by contrast, often occur at times when you reflect on your overall goals and aims in life. So: record TOCs whenever they come to mind; then keep this list to hand so that it is ready whenever you are feeling ambivalent about taking medication and are overwhelmed by TICs. The intervention requires that you counter every TIC with a TOC! If a TIC occurs when you are about to take medication, try to counter it with a TOC from your list. Your goal is to end each series of thoughts with a TOC. If you can do this, it may help you stick with your original plan to take medication. Box 8 demonstrates an example of TIC-TOCs.

Box 8 TIC TOCs	
TICs (Task-interfering cognitions)	TOCs (Task-orientating cognitions)
If I take these I might get side-effects	If you are going to get side-effects you would probably have them by now, you've been on this dose for 18 months without problems
It's a hassle to take medication every day	It'd be a greater hassle to end up in hospital
Missing doses when I'm well won't hurt	I might as well just get into a regular routine. Anyway, the leaflets that I read say that I need to take the medication long term to stop a relapse
I don't feel in control of my life when I take medication	Taking control of my life means minimizing the problems I have because I've got manic depression. I am choosing to control my symptoms by using medication and self-regulation

Cost–benefit analysis A cost–benefit analysis is a useful way of weighing up all the pros and cons of treatment. The exercise requires you to think about all the advantages and disadvantages of taking medication and the advantages and disadvantages of not taking medication. (In this approach costs represent the negative outcomes, not the actual financial price of the medication.) Box 9 shows an example of a cost–benefit analysis sheet completed by Geoffrey. A blank cost–benefit analysis form is provided in the Appendix (p. 235).

Box 9 Geoffrey's cost-benefit analysis	
<p><i>Advantages of taking lithium</i></p> <ul style="list-style-type: none"> • Treatment keeps me out of hospital • My family are less worried when I'm on lithium • I know I'm doing everything I can to keep my illness under control • It seems to be working for me; I've been free of episodes for two years 	<p><i>Disadvantages of taking lithium</i></p> <ul style="list-style-type: none"> • I hate blood tests • I've gained weight as a side-effect • Lithium can be toxic; for example, you can get kidney damage if the blood level is wrong
<p><i>Advantages of NOT taking lithium</i></p> <ul style="list-style-type: none"> • I have fewer things to carry around or remember • I'm in control of me, not the tablets 	<p><i>Disadvantages of NOT taking lithium</i></p> <ul style="list-style-type: none"> • There is a greater risk I'll have a relapse • I might have to go back into hospital which may jeopardize my job • If my wife finds out she'll be upset • The doctor has expressed concern for my well-being if I don't stay with medication • Once when I was depressed, I wanted to kill myself – it was very frightening and I don't want to go through that again

What do you notice about the completed analysis? Two things may come to mind. First, very occasionally a similar item appears in more than one column. For example, one advantage of taking lithium was that it reduced the risk of hospitalization. Being admitted was also a potential disadvantage of *not* taking lithium. Second, the benefits of adherence (the advantages of taking lithium, plus the disadvantages of not taking lithium) outweighed the costs. Geoffrey had not realized

before completing his own analysis that he had more to gain than to lose by staying on a mood stabilizer.

If you wish to increase your own medication adherence you will have to work hard to identify the benefits of treatment. If this is difficult, you might wish to seek the opinions of other individuals who have struggled with similar problems. This may also suggest to you additional ideas or actions that reduce the disadvantages of adherence or the advantages of non-adherence.

Tackling negative automatic thoughts If using TOCs or cost– benefit analysis does not help, it may be necessary to make a more detailed exploration of your negative thoughts about medication. To begin this process, you need to *recognize* and *record* each specific automatic thought. Next you need to pause and *review* this thought. Finally, you need to *respond* to this thought. This strategy of “*recognize, record, review, and respond*” is useful for tackling the thoughts that occur in many difficult situations. However, it takes some time to feel comfortable with this approach. Do not worry if you make several attempts before you are able to go through this process without a hitch. Approaches to automatic thoughts that are more resistant to change are described on p. 149–54. Below are some tips to help you work on your negative views of medication, followed by a worked example.

- *Recognize and record:* Can you write down in your own words your negative automatic thought about taking medication? Try to write down exactly what went through your mind, without modifying it. Now rate how much you believe this thought on a scale of 0 to 100, and rate your emotional reaction.
- *Review:* This negative thought represents the first idea that came into your mind. However, this does not mean that this idea reflects the facts. It is useful to try to establish the accuracy or helpfulness of your automatic thought. First, can you review the evidence that supports this idea, and then any evidence that goes against this idea? Next, can you review any alternative ways of thinking about this situation? Finally, in what way is this idea helpful or unhelpful to you (are there advantages or disadvantages to maintaining this view)?
- *Respond:* The final component of testing automatic thoughts about medication requires two actions. First, rerate your belief in the original thought (using the same 0 to 100 rating scale) and your current emotion. Second, to decide what else you may need to do. For example, you may wish to gather more evidence to support or refute your idea. Alternatively, you may wish to design an experiment where you record information about your progress prospectively to test out your idea more fully.

Let’s take the example of Alex (p. 122) again.

Alex was a businessman. He had noted that when he was away from home he often did not take a supply of mood stabilizers with him, so he tried to overcome this problem by keeping an additional bottle of lithium tablets in his travel bag at all times. However, he reported that despite this he was still at high risk of non-adherence when he went away to business meetings. By monitoring this problem Alex was able to identify some important cognitive barriers to adherence.

Alex’s situation and mood: “Sitting in my hotel room on the morning of an important

meeting about a contract for a new piece of work for my company. Taking the pill box out of my travel bag. Feeling anxious.”

Recognize and record – thoughts included:

- “This is an important job, my boss stressed it was important that I did this well, I really must be on the ball.”
- Negative automatic thoughts: “The tablets might slow me down and then I’ll make a mess of this.”
- Belief in thought: 85/100.

Review: Evidence FOR thoughts about the negative effects of medication included:

- “I read somewhere that lithium can slow down people’s thinking and that it can make you confused.”

Evidence AGAINST – thoughts about the negative effects of medication included:

- “I’ve been on lithium for 13 months and I don’t feel slowed down.”
- “I haven’t messed up previous meetings; my work has been of a high standard even while I’ve been taking lithium.”
- “The only meeting that went really badly occurred on a day when I didn’t take my lithium!”
- “Confusion only usually occurs if the blood level is in the toxic range; my last test was fine.”

Alternatives included:

- “I may just be putting all my worries on to the tablets, when really I’m just anxious that the meeting should go well.”
- “I’ll ask my doctor when I get back to town if there is any evidence that I have been slowed down by the lithium. If it was really true, maybe he could recommend another mood stabilizer.”

Advantages and disadvantages included:

- “Focusing on this thought is not advantageous to me at this moment. I need to be planning my meeting.”

Response:

- Belief in original automatic thought: 40/100.
- Mood: Less anxious.
- Action plan: I will read MDF leaflet on lithium and its side-effects when I get home, and if I’m still concerned I will contact Dr Foster and ask to discuss my worries at our next appointment.

A Last Comment

As a psychiatrist involved in the treatment of individuals with bipolar disorders, I am

tempted to write 20 pages on why I think you should try to stick with any medication prescribed. However, CBT has taught me that persuasion is much less successful than helping individuals discover for themselves why they are ambivalent towards medications. Also, it is important to have a choice of strategies to test out. If, despite the techniques outlined in this chapter, you are absolutely unable to convince yourself to keep taking your medication, I would like to suggest three things for you to do:

- Always tell your clinician. Some may struggle more than others to show 100 per cent respect for your decision (particularly if they are concerned about the consequences for your mental health), but they need to know.
- For your own well-being, never stop your medication suddenly. Always reduce medication slowly over several weeks or months (preferably under the guidance of a clinician). Suddenly stopping your prophylactic treatment may significantly increase your risk of relapse.
- Re-read the section in Part One of this book on the “no treatment option” (p. 33–4). It is also worth monitoring your progress in medication free periods, particularly noting fluctuations in your most common symptoms of mood disorder.

On a more positive note, if you do manage to maintain your adherence to medication, you may also like to negotiate with your prescriber to allow you to self-medicate to prevent mood swings developing into an episode of depression or mania.

Summary

- About 50 per cent of individuals on long-term medication do not take all the prescribed medication.
- The most common reasons for not taking medication are:
 - treatment issues;
 - lifestyle issues;
 - attitudes and belief about medication.
- Useful techniques for increasing adherence include:
 - *knowledge*: Is the treatment regime understandable, acceptable, and manageable?
 - *practical strategies*: prompts and reinforcement; self-monitoring and self-regulation; written treatment plans;
 - *cognitive strategies*: examining the evidence; TIC-TOCs; cost–benefit analysis; challenging negative automatic thoughts.
- If you stop taking medication:
 - always tell your clinician;
 - don’t stop your treatment suddenly;
 - monitor your symptoms during medication-free periods.

PART THREE

Self-Management of Depression and Mania

Aims of Part Three

At the end of Part Three of this book, I hope you will have improved your self-management skills by:

- understanding the characteristic unhelpful behaviors and thoughts associated with depressed mood;
- introducing key behavioral interventions that can increase activities, reduce problems, and improve your mood;
- learning how to apply cognitive strategies such as distraction and thought modification to develop a more balanced view of your situation, and to reduce depression and anxiety;
- understanding the characteristic unhelpful behaviors and thoughts associated with highs;
- introducing key behavioral techniques to help you relax, maximize your self-control, and avoid major problems;
- learning how to apply cognitive strategies such as active distraction and simple thought modification to develop a more balanced view and to reduce elation and irritability.

Self-Management of Depressive Episodes

For many individuals, simply undertaking self-monitoring and self-regulation as described in Part Two of this book will reduce the frequency or severity of mood swings. However, even if you are applying these techniques carefully, and have also worked hard to overcome barriers to taking medication as prescribed, it is still possible that you will experience some episodes of more extreme mood swings (beyond the +2/–2 ratings on your mood chart). These swings are usually accompanied by changes in your thoughts and behavior.

The two chapters in this part of the book are targeted at helping you deal with these more extreme episodes and trying to restabilize your mood. The present chapter deals with depression; the next (Chapter 10) with mania and other types of “highs”. Each chapter begins by looking at techniques to deal with unhelpful behaviors, and then moves on to techniques for modifying unhelpful or dysfunctional thoughts. By tackling these two areas it is usually possible to improve your mood and general functioning. However, it is important to bear in mind that this division into thoughts and behaviors is slightly artificial, as they influence each other as well as influencing mood.

Dealing with Unhelpful Behaviors

In Part One of this book we explored in detail the symptoms of depressive episodes and the vicious cycle of changes that may occur once depression sets in. The key unhelpful activities of individuals with depression are:

- *avoidance*, particularly of activities that give them a sense of pleasure or achievement;
- *withdrawal*, particularly from social situations that may offer support;
- *procrastination* – being unable to start or complete tasks, or solve problems.

It is easy to understand how these difficulties increase individuals’ negative views of themselves and further depress them. However, it is often difficult to break this cycle. Fortunately, building on previously learned techniques is a useful way to start. There are two main approaches:

- activity scheduling (including social interactions);

- step-by-step approaches to tasks and problems.

Activity Scheduling

You may already have found activity schedules helpful in planning your day and ensuring you take on neither too many nor too few activities. This strategy is especially important when experiencing a more severe period of depression. If you are finding activity scheduling difficult, here are some tips on how to cope with the most commonly reported problems.

Unable to do anything If your energy level is low and you are inactive, you probably get up in the morning and then spend a long time thinking about doing things, worry about not doing things, and remind yourself of all the reasons why you can't do anything. These thoughts tend to increase feelings of depression and anxiety. To break this cycle, you have to take action. Having a plan of action for when you wake up is an important first step. It is also helpful if the timetable you have to start the day with is basic and simple.

It is best to plan a daily schedule at least one day in advance. Early evening is a good time to plan the next day; setting a fixed time to write the plan is even better. If this is really hard, can you get someone to help you in writing the plan? If no one is available at home, can you telephone someone on a regular basis to talk your plan through or get ideas?

At the end of each day, review your timetable and note what you have learned from your schedule. If you did nothing, did it actually make you feel any better? The usual answer is no. If anything, inactivity tends to make depression worse. So it is worth trying to plan some activities for tomorrow. Taking action has two effects. First, it can actually distract you and give you temporary relief from your negative thoughts and feelings. Second, and most importantly, you will feel better sooner if you keep on doing the things that have made you feel better on previous occasions.

If you are really struggling to do anything, perhaps you could try a short exercise to see if these questions help generate ideas of what to do next. Simply try to list two activities that you can:

- do on your own;
- do with other people;
- do early in the day;
- do in the evening;
- do at night;
- do which are free;
- do which cost money;
- do which help you use your brain;
- do which help you relax.

These ideas will generate a number of possible activities, some of which will overlap in several categories. For example, doing a crossword puzzle is something you can do alone, at any time of day or night, and will use your brain. This overlap is not a problem; in fact one of my clients produced a matrix that she told me helped her pick just the right activity for any particular moment (see Table 3). I have included a blank copy of this matrix in the Appendix for you to complete if you wish (p. 236).

What if you did some activities but didn't feel any better? This is actually more likely. The most common problem is not a lack of any activity, but a lack of positive activities that give any sense of pleasure or achievement, or a lack of reinforcement for what you did. It is essential to give yourself positive feedback for *anything* you do when you feel so low. Try to avoid self-criticism or discounting your efforts. If you had broken your leg, you would not expect to be able to do everything you usually do, and would acknowledge the extra effort required in simply moving around on flat ground. Furthermore, you wouldn't expect to be able to run up a hill. It is very important to accept that depression is just as disabling as a physical injury. You must not expect too much too soon; but you can help yourself to recover by making gradual changes in your activities and thinking. Anything you are able to do is a valuable start. The next step is to include positive experiences in your schedule.

Table 3 Activity matrix

	Shopping with friend	Reading	Doing crosswords	Swimming	Running club	Watching TV	Going to the theatre
Do alone		✓	✓	✓		✓	
Do with others	✓			✓	✓		✓
Early in the day	✓	✓	✓	✓		✓	
Evening		✓	✓	✓	✓	✓	✓
Night-time		✓	✓			✓	
Free activity		✓	✓		✓	✓	
Costs money	✓			✓			✓
Uses my mind		✓	✓				✓
Helps me relax				✓	✓	✓	

Unable to enjoy anything or achieve anything A frequent problem with activity planning is that individuals try desperately to keep up with their obligations but fail to consider their own needs. (This issue is discussed in detail in Melanie Fennell's book in this series, *Overcoming Low Self-Esteem*.) A schedule that includes no planned enjoyable activities or time for yourself is probably too difficult to maintain if you are already feeling down. Also, low energy and poor concentration may make

it difficult to complete complex obligations. The goal is to set realistic targets and have a balanced plan of activities for your day.

Designing a more constructive schedule of activities begins with ensuring that any list of priorities (as discussed on p. 101–5) includes pleasurable activities. You could start by making sure that your “A” list of activities for each day contains an equal number of pleasurable activities and obligations. Many individuals report that when they feel depressed they are unable to think of any positive activities, so here are some questions that may help you:

- Can you list any hobbies or interests that you have?
- Can you record three things that you might enjoy doing?
- Can you list three things that you used to enjoy doing?
- Can you list three enjoyable activities that you always thought you might try in the future?
- If you talk to or observe other people, what activities do they engage in?
- Does the local library or community centre have any information on activities available in your area?

Some of the activities you note may be impractical or not manageable at present, but even so this list will give you some ideas of what you could try. If you are still struggling to get started, try reorganizing the list of activities you have come up with in order of (a) how likely you are to enjoy it and (b) the probable degree of difficulty. Starting with an easy activity that offers average or above average pleasure, can you now add at least one of these activities to each day of your schedule?

You can of course include some basic day-to-day tasks and obligations in your schedule. However, it is worth following some simple guidelines that will help to reduce the stress associated with such tasks. As discussed previously, it helps to list all the tasks and try to delegate some to other people. Next, check through the list and select the simplest tasks. Include one simple task per day, gradually increasing to two and then three as you begin to feel better and more in control. The benefit of this approach is that it makes inroads into your obligations and gives you some success experiences – and it is vital that you have some positive reinforcement. Completing an essential task, no matter how small, fulfils the criteria for a success and can be rated as such. It is also useful to try to follow the completion of an obligation with some sort of reward, no matter how small.

An essential part of this approach is to allocate a fixed amount of *time* to a task. When individuals are depressed, they are slowed down in their thinking and their actions, so some tasks take much longer than they would normally. If, while you are depressed, you set yourself a target of cleaning two rooms in your home, the danger is that it will take much longer than expected, and quite possibly fill most of your day. This will leave you feeling frustrated, with a low sense of accomplishment and with no time for other, more positive experiences. Rather than improving your mood, it may make life feel very empty. In contrast, setting a target of two hours’ house cleaning in the morning is much more manageable. No matter how slow your progress, simply sticking with the time allocated will be deemed a success. You can then give yourself positive feedback for your efforts; and, by identifying a clear time to stop, you are also enabling yourself to move on to other activities without feeling guilty. Furthermore, as your depression begins to lift, you will become more active,

have more energy, and be able to do more in the same amount of time.

The final stage in this approach is to review the list of more complex tasks and consider whether any obligations can realistically be postponed. If there are any important tasks that cannot be delayed or delegated to others, can you think of anyone who can help you to complete them? If the task is difficult but others cannot help, you may wish to follow the process described later in this chapter under “Step-by-Step Approaches”.

Unable to face anyone Individuals who are depressed frequently say that they doubt whether other people like them or want to spend time with them. Negative thoughts such as “I’m boring” or “They wouldn’t want to be with me if they knew what I was really like” are common. These thoughts are powerful and not easy to challenge. When they are combined with low activity levels, it is easy to understand how individuals become socially isolated. However, it is important to try to retain some contact with the outside world. Keeping in touch with people offers you an important source of support, and often provides valuable external feedback and reinforcement at a time when you are finding it hard to see yourself in a positive light.

It is not easy to make social contacts if you fear being judged by others, or worry about letting people down by not being good company. However, remember that you can control the frequency of social contacts and the pace of change. Perhaps you could try to include one social interaction each day for the first few days, and then gradually increase to two a day by the end of the week. The duration of the contact can also be built up gradually as you begin to gain confidence.

As with other activities, getting started can be difficult, so:

- First, can you generate a list of the social contacts that you have previously enjoyed or that you think you might enjoy.
- Next, can you note the name of anyone who usually makes you feel good about yourself?
- Finally, has anyone actually contacted you recently to arrange a social activity?

The next step is to reorganize the list in order, with the least stressful social contact at the top of the list and the most challenging social event or engagement at the bottom. For example, the top part of your list may look something like this:

- Buy a newspaper and try to hold a brief conversation with the shopkeeper.
- Call Jane and have a chat on the telephone.
- Accept Rosemary’s invitation to go to coffee (call beforehand and tell her I can only stay for 30 minutes).
- Take flowers round to Jackie who is at home recovering from the flu.

To help in the early stages, you could plan in advance (as in the third option here) to set a time limit for the interaction, as knowing the end point sometimes helps reduce any associated stress. You could also rehearse some topics of conversation or questions you could ask people so that you don’t feel at a loss for words when you first meet.

Some individuals prefer to recommence their social interactions by talking to people they don’t know well and by keeping the conversation light (talking about the

weather, the news). Others prefer to start by talking with or meeting people they trust and who know them well. There is no “best approach”. Begin with the social contact that you feel most confident (despite your depression) you can undertake. As with other activity “experiments”, review your progress, examine any changes in mood, and gradually work your way through the list you have developed.

Dealing with setbacks Although you will generally make progress in the right direction, if you follow the guidelines set out above, it is likely that some days will be harder than others. Still, though it may not seem like it at the time, we often learn as much from reviewing difficult days as we do from looking back over successful days. Examining some of the following themes after tricky days may help you identify why things did not go according to plan:

- *Being specific about your planned activity* Your schedule is more likely to work if you are absolutely clear about exactly what you are going to try to do and what time of day you will try to do it. If you decide that you will phone a friend and try to arrange to meet, you need to decide in advance which friend to call and when you will get in touch. If there is any room for doubt in the schedule, you may find that you spend too much of your day procrastinating about what action to take. It is also useful to compare your planned activity with your actual activity. Did you manage to carry out your plan? If not, what were the barriers? Can you overcome these problems? Was the day better or worse than you had anticipated?
- *Becoming aware of fluctuations in your mood* If you feel depressed and your plan did not help alleviate your sadness, it is all too easy to write the whole day off. However, by rating the sense of achievement and pleasure of each activity you will gather more accurate information. Even on a “bad” day, it is usual to have some variation in your A and P ratings. It is helpful to check whether you felt 100 per cent depressed for 100 per cent of the day or whether there were any variations over the day. Did any activities coincide with an improvement in or worsening of your mood? If a planned positive activity did not have the desired effect or outcome, can you work out why? Also, try to remember that each daily activity schedule is an experiment. You are trying to find a package of things that work for you. If an activity is not beneficial, how can you modify your approach or change the activity to improve your chances of success the next time you try it?
- *Acknowledging successes* Often, individuals stick with their activity schedule, and rate their sense of pleasure and achievement at the time of completion of the activity as quite high, but then discount their ratings at the end of the day. Classically, such individuals start a review of their day by saying: “Yes, I did all those activities, *but* this schedule is nothing compared to what I should be able to do . . .” It is important to try to fight this “yes but” approach. The best way to overcome the tendency to discount your efforts is to set clear goals for each day in advance and to reward yourself for doing what you set out to do. Again, if you find this hard to do on your own, you may consider sharing your plans with someone and then getting their objective feedback on whether you achieved your goals.
- *Giving yourself a chance* It may be hard to convince yourself that changing your activities will alleviate your depression. This uncertainty is totally understandable.

There is no 100 per cent guarantee that these approaches will work for you. However, the opposite is also true: there is no reason to assume that they won't. No matter how doubtful you are, there is actually nothing to lose (and much to be learned) by trying them out. It is entirely appropriate to be sceptical about the benefits of activity scheduling. But healthy scepticism means that you suspend your negative judgement until you have completed a fair experiment, not that you turn your back on the whole idea.

Step-by-Step Approaches

If you are depressed, you may feel overwhelmed by the tasks you want to complete or the problems that you face. The key to coping is to focus on one issue at a time and to take a step-by-step approach. Plan the approach, rehearse how to overcome obstacles, and then review your progress.

Dealing with complex tasks First, write the list of tasks; then put them in order of difficulty. Now, starting with the easiest task, see if you can break it down into smaller bites, and make a note of each separate step you need to take. As you become more skilled at this approach, you can work your way down the entire list so that eventually you have generated several manageable steps for even the most complex task.

Having repeated the process for each complex task, you now need to decide which task you prefer to start on. Tomorrow, try to complete step one of that task; the next day, try step two; and so on.

Breaking a large task down into several smaller tasks makes it much easier to work out what barriers there are to progress. Furthermore, having worked out each step, you can rehearse how to undertake each task in your mind and begin to predict potential sticking points. You may also be able to try techniques for overcoming any hurdles. Box 10 provides an example to help you understand this approach.

Box 10 Step-by-Step approach to tasks

Goal: To attend a daytime class at the community college

Steps:

- 1 Find out what the local college has on offer – walk down and get a brochure
- 2 Read brochure and choose possible courses
- 3 Check starting date and class times for three courses I might like to do
- 4 Make sure I can get a babysitter for class times
- 5 Call Joanne to see if she would like to go on a course as well
- 6 Come to a joint decision about which course
- 7 Go down to the college and sign up for the course
- 8 Attend first session with Joanne

Dealing with problems Unfortunately, being depressed does not relieve you of any other problems in your life. There is a temptation to avoid confronting problems; but, as most will not disappear, it is worth taking the same step-by-step approach to them. The critical first step is to turn each problem into a goal, viewing it as a target for you to aim at rather than a burden to overcome. This will help you begin to think about potential solutions. Having clarified your goal, can you now brainstorm all the

alternative ways you can achieve this target? Next, go through each approach and work out the feasibility of each strategy. For example, what are the pros and cons of each alternative solution? What are the advantages or disadvantages of the approach for your current situation, for the future, for other key people in your life? What barriers are there to implementing that plan? Having considered the alternatives, try out the most promising approach; then review its success. If that approach did not work, move on to the next potential solution. Again, to help you with this I have worked through an example in Box 11.

Box 11 Problem-solving
<p><i>Problem:</i> Not enough time to work on self-management strategies</p> <p>(Convert problem to a goal)</p> <p><i>Goal:</i> Increase the time available on a regular basis to review progress with self-monitoring</p> <p><i>Alternative solutions:</i></p> <ol style="list-style-type: none">1 Stop doing self-monitoring if I haven't got the time2 Delay starting self-monitoring for a few months3 Get a baby sitter or do a child minding "swap" with Gemma for a few extra hours a week4 Create time by delegating other household tasks such as family shopping to Alan5 Set time to read each day at coffee instead of listening to the radio6 Schedule a set time in my diary (Friday at 10 a.m.), write it in for three months in advance, and try to give it priority
<p>Having assessed the advantages and disadvantages of each approach, my preferred option is:</p> <p>Do a child minding swap with Gemma – this will give me two hours on Thursday afternoon</p>
<p>My reserve plan is:</p> <p>Set time to read each day at coffee</p>

Modifying Unhelpful or Dysfunctional Thoughts

The most common automatic thoughts that accompany a downswing are negative thoughts about yourself, your world, and your future (sometimes called the *negative cognitive triad*). The negative cognitive triad is associated with depressed mood, although negative predictions about the future are also associated with anxiety. As we shall see in the next chapter, irritability may also be a prominent emotion in highs and lows, particularly in response to perceived criticisms of what you do. Negative mood states can be alleviated temporarily by distracting yourself from the thought. However, to achieve lasting reductions in your depression and anxiety, it helps to be able to *recognize* and *record*, *review* and *respond* to your unhelpful automatic thoughts.

Recognizing and Recording Automatic Thoughts

It is not easy to identify thoughts immediately as they run through your mind, and it will take some practice. The two key elements that will help are to note down exactly what you were doing when you noticed that your mood changed, then to record how depressed or anxious you felt on a 0 to 100 scale. If you describe in detail what you were doing, the time of day, where you were, who you were with, you may find it

possible to recall what was going through your mind at that moment. If this is difficult, try closing your eyes and recreating the scene in your imagination. Ask yourself the following questions:

- What thoughts, memories or images do I have?
- What thoughts do I have about other people?
- What thoughts am I predicting they have about me?
- What do any of these thoughts say about me or my situation? About other people?
- If it were true, what does this idea mean about me? Or about others?
- What am I afraid of right now? What bad events or outcomes am I predicting?

Using this checklist of questions, you will probably be able to come up with some of the unhelpful thoughts that go through your mind. As with mood state, it is useful to rate the intensity of your belief in each thought on a 0 to 100 scale. Having rated your belief, pause to remind yourself that just because this is the first idea that came into your mind or the one you believe the most, this does not mean that it is necessarily the correct interpretation of the situation or event.

You may find that you have recorded several automatic thoughts. Before moving on to explore your thoughts it is helpful to make sure they accurately reflect your *immediate* reaction to the situation. You may be tempted to “tone down” a statement to make it less painful. Unfortunately, techniques for modifying dysfunctional thoughts are probably more effective if you deal with the raw rather than the polite version. For example, “I’m bad” or “I’m no good” are clear negative automatic thoughts that would make you feel down, whereas “I began to think I wasn’t very nice” or “I thought I didn’t do that very well” do not convey the reality of the thought or the depth of feeling.

Reviewing Your Automatic Thought

Having identified the automatic thoughts that are associated with your negative mood, it is important to follow a regular process of review. Rather than trying to tackle every automatic thought associated with your emotional response, try selecting the one that you believe most strongly, or the most extreme idea, and then review it in detail by working through the following stages.

Examine the evidence You will be very well aware of evidence that supports your idea, but are you attending to any evidence that goes against your idea, or any contradictions? To examine the evidence, list all the information that is compatible with your view. Stick with factual evidence, not feelings, intuition, or hearsay. Next, write down all the evidence that does not support your automatic thought. This will be harder, as such information is not at the forefront of your mind. To get started note anything that contradicts your thought, no matter how small. If you are still struggling, think about what you would say to someone else if they asked for your views of the evidence for and against the idea. You could also think whether you have any past experiences that support or refute your idea.

Having collected evidence for and against your automatic thought, is there any room for doubt that it is right? If you are still not sure, can you identify any sources of additional information that will help you reach a conclusion? What experiment could you do to test out the idea further yourself? Can you ask someone else how

they would view this idea? If you conclude that there *is* room for doubt, it is appropriate to explore what other views could be considered.

Considering the alternatives Having demonstrated that the first idea that springs into your mind may not represent the facts, the next step is to generate a list of alternative ways the situation *could be* viewed. Questions that may help include:

- What other views could I take of the situation?
- Would I view the situation differently if I felt better?
- Have I any experience of similar situations?
- How did I view those situations?
- What might someone else think in this situation, particularly someone who is not depressed?

This approach may generate at least one or two additional ideas that can again be examined to identify evidence for or against them.

Additional strategies In tackling your automatic thought, you may also question how helpful or functional it is for you to stick with this idea. Questions about this might include:

- Are there any advantages to holding this view? Are there any disadvantages?
- Can I identify any particular pattern of thinking errors, e.g. overgeneralization?
- Am I taking all the responsibility for a situation? Can I take a more balanced view, where I take some but not all of the responsibility for what has occurred?
- Finally, if my original idea is an accurate reflection of the situation, what is the most constructive and helpful action I can take?

Responding to Your Automatic Thought

Having examined your automatic thought, can you now re-rate how strongly you believe your original idea? By now, you are probably less convinced by it. Next, can you re-rate the intensity of your emotional response? It is unlikely that your depression or anxiety will have disappeared, but you may be able to rate your feelings less negatively. Finally, review the outcome of working through this process. What have you learned? Is there any other action you can now take to help you further in modifying this thought?

If there is no change in your mood state, consider whether there is any other powerful thought operating that you have not yet examined. If so, it is worth repeating the process, targeting this new thought.

Lastly, it is important to use these cognitive techniques alongside the practical techniques outlined in the previous section. The combination is likely to improve your mood state more than either approach alone.

It will take practice to feel comfortable with the process of challenging and modifying your automatic thoughts and coming up with more balanced views of your experiences. To help with this process, I have included an example of a thought record in Table 4.

A blank thought record is provided in the Appendix of this book (p. 237). Ideally, you should copy this template and use it regularly, keeping your automatic thought

records for future reference. Reviewing several automatic thought records can enable you to identify common patterns in your dysfunctional thinking, such as jumping to conclusions or mind-reading (as described on p. 49). The records may also reveal themes in the events or experiences that you find stressful, thus helping you to plan for the future. Also, these records may help you identify some of your own underlying beliefs.

Hopelessness: A Special Case

If you are depressed you may get thoughts that make you feel hopeless. Unfortunately, some individuals who feel intensely hopeless about their future begin to think that they cannot carry on. In order to keep yourself safe through these difficult times, it is important to remember that the automatic thoughts that are making you feel hopeless can be tackled through the same techniques as those used for anxiety or depression. What evidence is there for your thoughts? What alternative ways of viewing your situation are there? What activities could you undertake right now to alleviate these feelings, even for a short time?

Table 4 Tackling unhelpful thoughts in depression: the thought record

Situation or event	Emotion (rated 0-100)	Automatic thoughts (belief rated 0-100)	Evidence for and against the thought	Alternative view	Re-rate emotion and belief in original automatic thought	Action or outcome
Susan, my best friend didn't return my phone call	Anxiety 70	She can't be bothered with me any more 80	Evidence <i>for</i> : none Evidence <i>against</i> : Susan rings regularly and has been a real help and support for years I'm thinking this way because I'm down	I can't guarantee her son passed on the message; she might not know I called Even if she knew I'd called she might be very busy, and just not had a chance to get back When Susan and I have ever had any difficulties in our friendship she's been the first to sit down and sort it out; she'd have said if she had a problem She is actually allowed to go out with other people!	Anxiety 45 Thought 30	<i>Outcome:</i> I realize I'm thinking in a very negative way and I don't actually have the facts <i>Action:</i> Ring Susan again with a definite proposal for some time out to do something we both enjoy If no answer by phone, drop by her house next Tuesday to check she's ok
	Sadness 80	She's probably out with more rewarding friends, i.e. she doesn't like me any more 65	Evidence <i>for</i> : none Evidence <i>against</i> : Susan told me only last week how much she valued my friendship Jane told me that Susan had been saying when they met how much she liked me		Sadness 50 Thought 20	

If you really cannot overcome your hopelessness it is important to talk to someone else. This becomes vital if you have any associated ideas about harming yourself. If these thoughts flood your mind and you are feeling too down to tackle them alone, please seek help.

Keeping Going, and Seeking Help

Even with practice, there will be times when it is very difficult to use the techniques described in this chapter. You may find it hard to focus on thoughts, to write things down, or to take action. It does take an enormous effort to start using these

approaches.

If you are struggling to implement these strategies, can anyone offer you support in your efforts? Even someone offering encouragement to try self-management approaches may help you get started. Other approaches to the management of depression, such as professional input from mental health and self-medication with anti-depressants, are also important and will be discussed further in the Chapter 11 on relapse prevention.

Summary

Self-management of depression involves:

- Understanding *Unhelpful Behaviors* such as: – avoidance;
– withdrawal;
– procrastination.
- Using key *Behavioral Interventions* such as:
– activity scheduling;
– step-by-step approaches to tasks & problems.
- Identifying *Automatic Thoughts* particularly those focused on:
– negative views of the self world & future;
– these thoughts are associated with depressed and anxious mood.
- Using key *Cognitive Strategies* such as:
– distraction;
– modification of unhelpful thoughts by examining the evidence, generating alternatives, and devising experiments to test out ideas.
- Being alert to feelings of *Hopelessness*. This is a particularly difficult symptom to cope with. Additional help and support is needed if this feeling is persistent and intense.

Self-Management of Hypomanic and Manic Episodes

When an individual experiences a “high”, their mood change is often compounded by difficulties in recognizing that their actions are extreme and outside of normal boundaries. Also, they are easily distracted and unable to focus on the task in hand. This means that it is important to try to keep any self-management interventions simple. This chapter describes techniques to control unhelpful behaviors and basic strategies to modify unhelpful automatic thoughts. However, these techniques are most effective in the early stages of a high; it is unlikely they will be feasible if you are in the midst of a manic episode.

Dealing with Unhelpful Behaviors

The main difficulty for individuals who are experiencing a high is that they have too much energy, and struggle to exercise full control over their own actions, which may involve a worrying level of risk-taking, or be open to misinterpretation by other people. This in turn may lead to the individual becoming irritable with people who prevent them going ahead with what they want to do. The key unhelpful tendencies are:

- *distractability* – inability to complete tasks;
- *risk-taking* – engaging in ill-judged activities through overestimating the gains and/or underestimating the dangers;
- *impulsivity* – acting without thinking things through, often associated with disinhibition;
- *irritability* – common in dysphoric mania, but also present in euphoric mania when actions are thwarted by others.

There are a number of strategies that can be tried to help reduce the adverse effects of these behaviors, but it is very difficult to use any of these techniques during a manic episode. It is therefore important to try to intervene as soon as the warning signs of a high are present, or at the latest during the hypomanic phase. The two basic approaches involve:

- keeping safe;

- maximizing self-control.

Keeping Safe

If you do not feel able to control all of your actions or totally trust your judgment, it is worth reducing your exposure to “risky” situations. Preparing plans when you are in a normal mood state that can be used when you are high is invaluable, as it is often difficult to put these approaches in place during a high without the help of others. Useful interventions include the following:

Keeping schedules simple and predictable Make a very basic, manageable and regular activity schedule. Even if you are full of energy, it is better to reduce rather than increase your planned activities from their normal level. Allow time between one activity and the next, as you are likely to find it difficult to retain your focus on each task. Don’t skip eating or sleeping. Indeed, make a particular effort to include regular meals, and regular times for going to bed and for getting up. Aim to spend at least 50 per cent of your daily schedule in a calm environment or engaging in relaxing activities. Try to avoid two areas:

- *Complex tasks or problems:* Keep your goals simple and delay any major obligations. If you do need to undertake simple tasks, try to persist with the activity until it is complete. Remember that when going high you are more easily distracted and at risk of starting lots of activities and finishing none. Push yourself to stay with each task before moving on to other things, no matter how attractive other activities may be. (This is the opposite advice to that for depression, where we used time limits.) If there are complex tasks that cannot be delayed, do not start them without recording a step-by-step approach and preferably enlisting the support of someone else.
- *Stimulants and stimulating people:* Try to avoid situations, substances or people that push you even higher. One of my clients designed a “VROOMOMETER”, a chart listing activities that she was able to cope with at different stages in an upswing. She drew it up when she was in normal mood, and found it invaluable in picking out activities that were safe when she was in the early and later stages of a high. An example of such a chart is given in Figure 11.

Having made your plan, try to stick with it. Even if you feel full of energy, don’t try to add more into your day. The risk of inappropriate actions or problems is high and is better avoided. If when you review your day you do not feel you are using up enough of your energy, can you burn off some energy through exercise in a safe environment – for example, by swimming several lengths of a swimming pool? However, you must feel confident you can cope with that environment. If not, can you use an exercise bike or follow an exercise video in the confines of your own home? Try not to set endurance tests for exercise. It is better to attempt about half an hour per day and then review your schedule after four or five days to decide if any more exercise is likely to help calm you down and reduce your excess energy.

Calming activities As well as avoiding activities that are stimulating, it is important actively to calm yourself. This is achieved by ensuring that you incorporate

relaxation sessions into your day, and also introduce other methods to reduce your level of arousal. For example, stay in familiar surroundings. You could even use a particular room in your home where you feel comfortable to take time out. Here you could lower the lighting or even sit in the dark for about an hour. Listening to relaxing music may help. Also, try to avoid exciting books or films if possible. A boring book is a good idea, particularly at bedtime! Slowly repeating simple phrases to yourself such as “relax”, “calm down”, or “take your time” may also work.

Figure 11 An Example of a “Vroomometer”

GREEN ZONE SAFE EVEN WHEN +6	—	Aromatherapy	CALMING ACTIVITIES
	—	Nice long hot bath	
	—	Gentle exercise	
	—	Listening to relaxing music	
	—	Reading, watching TV	
AMBER ZONE AVOID IF GREATER THAN +4	—	Watching thriller movies	
	—	Nights out with Ronnie	
	—	Meeting members of college course for lunch	
RED ZONE TOO MUCH IF I'M AT +2/3	—	Going to Discos with Jackie & Helen	
	—	Night out with the volley ball team	
	—	Visit to the Casino for late night gambling	
			STIMULATING ACTIVITIES

Safe thrills If you do not seem to be able to resist seeking out excitement, try to identify safe pleasurable activities. For example, rather than taking flying lessons, can you get access to a computer that has a flight simulator program on it? Rather than driving your car at speed, can you watch a video of a grand prix? These alternatives may seem less appealing, but it is important to remind yourself that the consequences are much less dangerous. If you feel compelled even to try these safer alternatives,

limit your exposure to a maximum of about half an hour per day and preferably engage in calming activities immediately afterwards. Ideally, you should avoid even safe thrills if you are becoming manic, as the additional stimulation may have adverse rather than beneficial effects.

Managing social situations As emphasized earlier, it is wise to avoid some social interactions, particularly those that involve large gatherings of people. If you do engage in social interactions, try to space these activities out over the course of the week, and where possible keep the rest of your schedule regular and predictable. In any social interaction it is worth doing the following:

- If possible, sit down on a chair before you start talking.
- Sit upright and try to control your breathing.
- Work hard at listening to the other person's comments.
- Don't interrupt, no matter how keen you feel to join in.
- Wait for a gap in the conversation before speaking.
- Pause before you begin talking.
- Speak at a rate that seems slow to you.
- Do not use your hands as you talk – if necessary, try sitting on them!

Although you may feel very slowed down by this approach, it usually only just brings your activity and speech rate within normal bounds. If you are concerned that you have overcompensated and have slowed down too much, check this out with someone you trust.

Maximizing Self-Control

If you are going high, you may be full of ideas and bursting with things you want to do. As a consequence, you can get frustrated and angry with people who fail to see the apparent brilliance of your plans or who try to stop you carrying out your planned actions. One way to reduce the risk of becoming angry is to try to increase your own control over your actions. The simple rule is: "Control what you can control, and don't engage in behaviors that you can't control." If you are unsure whether you can retain control it is better to delay things than risk problems. To overcome your desire to act, you may wish to try the following ideas.

Record your idea or plan You may be convinced that all the ideas you have are good ones and should be implemented. However, it is worth trying to contain your impulsiveness. The apparent brilliance of your ideas is not always a reflection of reality. Individuals who are going high tend to notice only the strengths of an idea and are not always able to focus on the weaknesses. To help you avoid getting into battles or risky situations, keep a notebook to hand where you can record your ideas. You can then return to evaluate these ideas after you have recovered from your high. It will also be easier to convince others of your good idea if you present your plan after you are back to your usual self. If you follow this approach you actually have a greater chance of getting genuinely good ideas adopted, as they will not get lost in the mass of less viable proposals. You will also maintain your credibility as someone who does have moments of inspiration, rather than gain a reputation as someone full of erratic ideas.

Ban major decisions Maximizing self-control primarily involves restraining yourself from doing anything that you may regret later. It is vital that you do not make any major decisions about your personal or professional situation. Not everyone you meet will know that you are not your normal self, and some may take your decisions at face value. It is important to avoid decisions that have major consequences for your future, such as beginning new relationships or changing jobs. Any important decisions that you wish to contemplate should be listed in your notebook for future consideration.

This approach means that no one is taking decisions away from you or denying you the opportunity to lead your own life. You are retaining control by taking the initiative and choosing to delay any irreversible decisions.

48-hour delay rule Professor Aaron Beck, the father of cognitive therapy, has developed many of the approaches used to help individuals with bipolar disorders. One of the important techniques he describes is the “48-hour delay rule”. He states that “If it’s a good idea today, it will still be a good idea tomorrow and a good idea the next day.” This is a useful approach to many situations, but can be particularly useful in avoiding impulsive purchases, especially of very expensive items that you would not normally consider buying. During the 48 hours you have the opportunity to reflect on your plans and most importantly to seek advice from others on the wisdom of your proposed course of action.

An additional way to prevent financial extravagance is to surrender control of your credit cards to a trusted friend, or even to have an arrangement with your bank or financial adviser. Again, look at this as your attempt to take maximum possible responsibility for your actions, no matter what your state of mind. Getting help to prevent overspending will enable you to avoid some of the desperate financial problems that many other individuals have had to cope with after recovering from a high.

Third-party advice Individuals who are high find it very frustrating to have people criticize any proposals they make, and dismiss negative feedback as jealousy or lack of imagination. To overcome this, it is useful to identify in advance (i.e. when you are in a normal mood state) at least two people whose opinions you respect and whom you trust. You can then arrange to turn to these individuals when you are high to seek feedback on your ideas and planned actions. Having at least two people available offers a safety net in case you cannot contact one of them at the vital moment. If possible, you may even arrange that they regularly initiate contact when you are high and ask you to report any ideas you are considering acting on. They may be able to talk you through the pros and cons of your ideas, or help you record them. They can encourage you to return to these ideas when you are back to your usual self.

Modifying Unhelpful or Dysfunctional Thoughts

Being high is usually associated with positive but unrealistic automatic thoughts about your abilities and prospects for future success. Classically, individuals have an overoptimistic view of their world, in which they:

- overestimate the gains and underestimate the risks associated with any ideas;

- are totally focused on their own wants and needs;
- fail to attend to any negative consequences of their actions for themselves or others;
- experience angry thoughts as a consequence of their reduced tolerance of frustration.

Individuals who experience dysphoric mania also report negative automatic thoughts and irritability. (If this applies to you, you may find it helpful to use the approaches to unhelpful thoughts described in Chapter 9 on dealing with depression.) Techniques for modifying the automatic thoughts that accompany a high are outlined below.

Active Distraction

If you are finding it hard to contain your wish to act on an idea, can you try to distract yourself from this course of action by thinking about other topics or by blocking the thoughts? Selecting another focus for your attention is helpful provided you do not simply move on to the next “big idea” that you have. Likewise, simply letting the first thought melt away is unlikely to resolve the situation, because your mind is working overtime and generating lots of new ideas. The critical element is therefore to distract yourself actively and to find a strong focus for your thinking that leaves no room for drifting back to your first automatic thought. Some individuals have particular images that they use; these may be relaxing scenes, or sometimes visions of the bad outcomes that have occurred in the past. You will need to try this technique a few times to establish whether it works for you.

Another approach is “self-talk”. Try repeating statements such as “I can resist this urge,” “I don’t have to act on this now,” or simply “Stop, it’s dangerous.” Keep the statements simple and repeat them as often as you can until you feel more in control.

The Two-Column Technique

If you are overactive and easily distracted, it is often too difficult to undertake a careful review of your automatic thought using the techniques described for depression. At best you may be able to push yourself to reflect on your ideas and to write down the pros and cons of any thought. However, it is important that the lists you compose bring in the information that is outside of your immediate focus of attention.

For example, when you feel high, you will tend only to see things from your point of view, or to see the enormous potential of the idea or the benefits of the scheme you propose. The critical aspect of the “two-column” technique is to ensure that you pay attention to the alternative. Namely, for each positive statement you write down, you should immediately respond with a statement on the downside of your idea. To help with this approach, ask yourself the following questions:

- What *harm* might this idea do to *others*?
- What is the *destructive* potential of the scheme?
- What are the potential *losses*?

You will have to work hard to come up with answers, and if this proves difficult you may wish to consult others to help you in completing this task. For example, can you

call on the individuals you have nominated for third-party advice (see above)?

Table 5 gives an example of the “two-column” technique. Some blank copies of this form are included in the Appendix for your own use (pp. 238–40).

Table 5 The two-column technique for tackling unhelpful thoughts when high

<i>My idea: Give up work and use the money I get on leaving to buy a farm</i>	
<i>Reasons for acting on my idea</i> (benefits to me, constructive aspects, gains)	<i>Reasons against acting on my idea</i> (risk of harm to others, destructive aspects, losses)
<p>I've always loved the idea of living in the country</p> <p>I can learn a whole new set of skills and become a farmer</p> <p>I'll be able to do what I want, I'll be my own boss and make lots of money for my family</p>	<p>My wife prefers living in cities</p> <p>The children would have to leave school in the middle of their studies</p> <p>My wife and children would leave all their friends behind</p> <p>I don't know the first thing about running a farm</p> <p>There may be tensions at home. My wife would also have to learn new skills. If she doesn't want to do this, it will damage our relationship</p> <p>My wife and children might not agree to move to the country</p> <p>Farming is actually a very busy job and some tasks have to be done at set times, so I may have less freedom than I think</p> <p>Lots of people are struggling to make money in farming</p> <p>The thing I like best about the countryside is visiting it; that doesn't mean I would enjoy working there</p>
<p><i>Conclusion:</i> I still think I want to live in the country, but I may not actually want to run a farm. Use 48-hour delay and contact Ruth and Mark (third-party advice).</p>	

Modifying “Should” Statements

A common accompaniment of a high is increased irritability. If this is not tempered it may spill over into anger. Given that you may also be less inhibited than usual, the whole situation may become dangerous. Prevention is obviously important, but you are only likely to be able to take full responsibility for your anger and irritability in the early stages of a high. Later, you are unlikely to be able to control your emotions and actions without professional support and recourse to medication.

Step one in averting difficulties is to keep a list of situations that you know “wind you up” or frustrate you even when you are symptom-free. Ideally, arrange to stay away from the situations or people involved until you feel more settled and able to cope. If you find yourself in situations where you are becoming irritable and cannot immediately withdraw, there are two approaches you can try:

- engage in one or more relaxation or calming techniques;
- try to employ the social interaction skills discussed earlier in this section, particularly sitting down to talk, and speaking calmly and slowly.

Most irritability and anger can be traced back to your automatic thoughts. Thoughts that contain “should” statements are particularly powerful: “She should not talk to me like that,” “He shouldn’t try to stop me,” or “I should be allowed to do what I want.” While you may not be able to follow a systematic process of exploring these thoughts in the heat of the moment, you can still try to reframe them in less emotive terms. For example, every time a “should” statement goes through your mind, can you reframe it as “I would prefer it if . . .”? This does not change the fact that you have a negative thought, but it may help reduce the intensity of your reaction, and make the thought and your emotions more manageable. You could also try reminding yourself of the disadvantages or potentially negative consequences for you of acting upon your negative thought.

If you are still reasonably in control of your high, you may be able to review and modify your thinking as described in Chapter 9 on depression. Begin by noting the event or situation in which your negative thoughts arose, and the intensity of your emotional response. You may well find that many automatic thoughts that are associated with anger or irritability arise after someone has made a comment that you perceive as critical of you. Anger and irritability are often secondary emotions, arising in situations where your first response is that you feel hurt or upset. The good news is that you can stem your descent into irritability or anger if you can identify and challenge your initial negative automatic thought and deal with any hurt you are feeling.

Hidden behind the bravado that accompanies a high there may well be a fragile self-esteem that is easily wounded. Furthermore, many individuals report that as they come down from a high they feel quite depressed. This is an important time to be vigilant about comments you view as critical. You need to explore the evidence and examine the alternatives. Next, can you assess how accurate the comment is and also what would it mean if it were true? How could you change things if it were true? Finally, can you assess how sensitive you are being to other people’s comments? If you are being oversensitive, how can you manage your reactions differently?

Here is an example.

Steven was slightly high and feeling sociable, so he went into the canteen at work and sat down with some colleagues who were already chatting to each other.

Steven was mildly disinhibited and began talking across the ongoing conversation. One of his colleagues said, “Please don’t interrupt just yet, Steven.” Steven felt angry as he wanted to tell them about some interesting ideas he had. However, before telling the colleague what he thought of her, he decided to try to review the situation and work out why he felt angry.

- *Situation:* With colleagues; asked not to interrupt.
- *Angry thoughts:* “She shouldn’t talk to me like that. She made me look foolish.”
- *Initial automatic thought:* “Maybe she doesn’t like me. They don’t want me to join them.”
- *Initial reaction:* Anxiety, hurt.
- *Steven’s response:* She actually smiled when she said “Please don’t interrupt,” and she did say “just yet”. The person they were listening to was just delivering the punchline of a joke.
- *Steven’s decision:* Try to stop mind-reading; also note I’m a little bit disinhibited and need to sit down before I speak.

Steven rated the *perceived criticism* as 40 per cent, but rated his *perceived sensitivity* as 75 per cent.

Keeping it Simple; Preparing in Advance

In writing about techniques for managing highs I have tried to pay attention to the fact that you are likely to be more distractible and disinhibited than normal. I realize you will struggle to implement some of these approaches. This chapter has therefore concentrated on simple techniques, rather than complicated sequences of interventions. However, even simple techniques will be hard to use when you are going high, and will be virtually impossible once you are in the midst of a manic episode. So, the more you try out these skills when you are your normal self, the greater your chance of being able to use them effectively when you are going high. As with depression, the role of other approaches such as self-medication and professional support are considered in the next chapter, on relapse prevention.

Summary

- Self-management of highs includes: *understanding unhelpful* behaviors such as:
 - distractibility;
 - risk-taking;
 - impulsivity and disinhibition;
 - low tolerance of frustration.
- Using key *behavioral interventions* such as:
 - keeping safe;
 - maximizing self-control: controlling what you can control; delaying or avoiding what you can’t control.
- Identifying *automatic thoughts* particularly those focused on:
 - overestimation of gains, underestimation of losses; – overoptimistic predictions;
 - excessive focus on the self.

These thoughts are associated with feeling elated, but also with irritable mood.
- Using key *cognitive strategies* such as:
 - active distraction;

- modification of unhelpful thoughts using the two-column technique; modification of “should” statements by reframing.
- These techniques are best implemented in the early stages of a high, as they are unlikely to prove feasible during a manic episode.

PART FOUR

Putting It All Together

Aims of Part Four

At the end of reading Part Four of this book, I hope you will have developed a plan for the future by:

- identifying and recording your own “relapse signatures” for key mood states;
- developing a relapse prevention action plan including self-management, self-medication, and early contact with key supporters, including professionals;
- identifying how to improve your view of yourself and develop a set of future life goals;
- devising a plan to encourage you to use cognitive and behavioral strategies in the future.

Relapse Prevention

Before describing in detail the key elements of the relapse prevention package, I thought I would relate a story:

Ian was a clinician working at a hospital that frequently carried out fire drills. The fire alarm was tested regularly on a Monday morning, but once a year there would be a full-scale fire practice with hospital staff required to follow the exit signs and congregate at various points in the hospital grounds. In order to cause the minimum disruption to the working week, the date and time of the annual fire drill were posted on notices around the hospital several weeks in advance. Despite this, Ian failed to take note of the date. As usual, the Monday morning alarm went off. Ian assumed it was the usual weekly test and of course ignored it. He was therefore extremely irritated when ten minutes later his teaching seminar was interrupted by a fire officer who was checking rooms to make sure everyone had vacated the building. The officer duly asked the seminar group to make their way to the assembly point in the hospital grounds. Ian pleaded with him not to interrupt his work, explaining that he was very busy and had other priorities. What was more, Ian said to the officer, he had worked at the hospital for years and knew what he should do if there was a fire. If he was in any doubt, Ian pointed out, there were laminated notices stuck on the back of each office door with details of the drill.

The fire officer listened patiently to Ian's protests and then smiled. "Well," he said, "if you have worked here for years you probably do know what to do if there's a fire. Our reason for carrying out this exercise is to make sure that you will all be safe if ever an emergency occurs. To reassure me that you will be safe, perhaps you could write down the key points written on the fire notice on the back of your office door and then talk me through the route you would need to take to get to your allocated assembly point." Needless to say, Ian didn't even try; as the students were only too aware, he didn't have the answers. With as much dignity as he could muster, Ian followed the exit route and participated in the fire drill.

This story is used to illustrate a simple but crucial point. Ian failed to notice the date of the full-scale practice despite the information being all around him. He also thought he knew what to do, he believed he knew what was written on the laminated information sheets that were within his gaze most days of the week. Ian believed he knew action to take if problems arose, to the extent that he did not feel the need for

rehearsal.

You may recognize the parallels between this story and your own situation. You may think you know the risks, and you may even know the symptoms that warn you of an impending mood swing. You have probably read about self-regulation and self-management. However, can you recall your early warning signs and symptoms, and the key interventions, right at this minute? Can you write them down? Most importantly, there is a difference between knowing the theory and actually being able to take the appropriate actions. How confident are you that you can implement the actions required to stop things getting worse? Can you rate on a 0 to 100 scale (100 = totally confident) how confident you are that you can implement a relapse prevention strategy? If you score less than 100, you may wish to read on.

This chapter of the book is aimed at helping you ensure you are confident that you can implement a relapse prevention package even when you are having a difficult time. It is actually very helpful to think about relapse prevention as a fire drill. It emphasizes that it should be a routine with which you are so familiar that you will be able to follow it under stress almost without having to think about the next step in the sequence.

Knowing Your Relapse Signature

If you watch a television show regularly, you will become very familiar with the signature tune. You have heard it so many times that, if you hear the first few bars of the tune, you can probably sing the next few notes. You can confidently predict what comes next. The same principle can be applied to identifying times when you are at risk of experiencing a significant mood swing. “High-risk” events or behavior may act as triggers. Alternatively, you may not be certain about the likely triggers, but you may recognize the early warning symptoms of an episode. These two elements form your personal “relapse signature”.

Triggers

In Part Two of this book we explored “high-risk” events, situations, and behaviors and recorded those on a risk list. Look over that list now. Are there different risk factors for different mood swings? If you did not identify any risk factors when you first read Part Two, you may wish to go back to your schedules and charts to see if you can find any clues about potential triggers for mood disorders.

Any triggers should be recorded on paper, using a separate sheet each for depression and highs. You may wish to include additional sheets for mixed states or other problems such as rapid cycling.

Early Warning Symptoms

More than 80 per cent of individuals with a mood disorder can identify key symptoms that occur in the month or so preceding the onset of a full relapse (this period of time is called the *pro-drome*). These prodromal symptoms constitute the second level of the relapse signature. They may provide the only warning of an impending relapse in those who cannot identify triggers. More often, the symptoms signal the progression of the relapse process to a dangerous phase where action will

be needed to prevent an episode of mood disorder.

Identifying your early warning symptoms is easier to do if you can refer to your symptom checklist. You may already have starred the symptoms that occur in the early stages of each relapse (see Table 2 on p. 69), if not, try to reorganize your list of symptoms into the order in which they usually occur. If this proves difficult, you could try to think about your most recent episodes of highs or lows, and establish what the first changes were that you noticed. If you are still struggling, you may wish to seek help from someone who has observed you during your mood swings. They may be able to help you identify between three and six symptoms that occurred earlier on in each episode.

The next step is to examine the three to six symptoms you have identified. Try to estimate how long before the full relapse each of these symptoms occurs. Now try to decide which symptoms are the most memorable *at the time they occur*. Which are you most aware of, which are most out of keeping with the way you usually behave, which are the most severe? These symptoms are probably the most robust markers of an impending relapse, and are the best ones to focus on.

Using this information, it is usually possible to identify accurately at least three symptoms from the prodromal phase of a high and three from the corresponding phase of a low that will alert you to the risk of a relapse. These constitute your early warning symptoms. In selecting the three key symptoms, try to exclude those that you are more conscious of in hindsight (e.g. feeling on top of the world when you are going high), and if you can, have three unique symptoms for each phase. If sleep disturbance is present in both phases, try to have three additional early warning symptoms on your list. Some individuals prefer to have four or five early warning symptoms. This is quite acceptable, but fewer than three may reduce the reliability of your relapse signature.

For mania, you may be able to identify early warning symptoms that only ever occur when you are at risk of relapse. This is not always possible for depression. You may find that there is a gradual worsening of your baseline level of depressed mood or concentration. If this is the case, try to clarify what degree of change in the severity of that feature would cause you concern.

Interestingly, the prodromal phases for any one individual are fairly constant, for both mania and depression. If you have identified that your early warning symptoms occur over a period of four weeks for one manic episode, there is a strong likelihood that the prodromal phase of any future manic episodes would be of the same duration. On average, the prodromal phase of hypomania or mania lasts for about three weeks, although the full range extends from a few days to about three months. The average prodromal phase for depression is actually slightly shorter than for mania (many people are surprised by this), being about two weeks, with a range of a few days to about five weeks. Despite the smaller “window”, with practice it is usually possible to institute an action plan aimed at averting a major depressive episode.

Frequency of Monitoring

The final component of the relapse signature is to establish how frequently you should check for the presence of triggers or early warning symptoms. It is important not to overdo this – for example, you are unlikely to need to check every day. If the

occurrence of the triggers or early warning symptoms is predictable (e.g. at certain times of year), you may decide to check for them once a month during the low-risk periods, increasing to once a week during high-risk periods. The presence of the first early warning symptom heralds the time for more intensive monitoring (such as daily or every other day). This allows you to establish whether any other early warning symptoms occur and to evaluate which interventions prove helpful.

Developing an Action Plan

The action plan is a written record of the strategies that can be used in response to the relapse signature. The interventions are usually listed in the order in which they will be introduced. The basic sequence includes increasing self-monitoring and self-regulation, followed by a selection of cognitive and behavioral self-management strategies. Ideally, you will be able to identify through experiments the specific interventions that you find particularly acceptable and effective.

Reviewing Previous Relapses

An additional route to identifying useful interventions is to review the details of your most recent relapses. What types of problems arose in implementing your action plan? Can you or anyone else identify ways in which you could prevent or reduce these barriers next time? If there are ways, it is worth adding those new strategies to your action plan. If no obvious practical barriers existed, you may need to consider whether any negative thoughts reduced your motivation to implement the plan. It may help to challenge these thoughts or develop some self-statements that will encourage you to put your plan into effect.

Self-Medication

The next stage of an action plan may include self-medication strategies. The principles and potential benefits of self-medication are easily understood. The strategy allows a person at risk of mood disorder to keep an additional supply of anti-psychotic, mood stabilizer, or anti-depressant medication in their possession. This gives the individual an early opportunity to increase the dose of a particular medication, or institute a new course of treatment, in response to changes in their mood and functioning. The actual changes in mental state that would lead to self-medication, and the exact nature and limits of any changes in the treatment regime, are agreed in advance with the prescriber.

Not all clinicians will agree to collaborate in this approach. They may be particularly reluctant if they have any anxieties about the safe implementation of self-medication, or if there have been significant problems with medication non-adherence in the past. Before including this strategy in your action plan you will need to talk with your clinician to determine whether this approach is acceptable to both of you.

Setting up Support Systems

The last stage of the action plan involves working out how to mobilize support at the

earliest appropriate time. Support may be enlisted from individuals in your social network and mental health professionals. If you can, identify about three individuals whom you could contact in a crisis. Having more than one option is obviously important, as this reduces the risk of your being left without support at the vital moment. Next, you need to ensure that you have contact details for each individual and are clear about their availability. With any clinicians or professionals, make sure you have established if they are available outside of normal office hours, or whether there might be different contact numbers you need for evenings, night-times, or weekends. Your action plan may also include the name of anyone you trust whom you wish to nominate to be involved in key decisions about your treatment, or who you would like to take any major decisions on your behalf.

Communicating Your Action Plan

Having recorded your relapse signature and action plan for each type of mood swing, you now need to decide who should receive a copy. Obviously anyone who is mentioned in your plan, particularly as part of your support network, will need to have a copy, as will key members of the professional mental health network. You then need to decide whether to give a copy of the plan to any members of your family or friends who do not have an identified role in your relapse prevention package. Finally, you will require readily accessible copies for your own use. Ideally, note your relapse signature and key elements of your plan on a flash card (a piece of paper the same size as a credit card) which you can keep with you.

Examples of Relapse Prevention Packages

Anne had a history of bipolar disorder. She had identified that episodes of depression were often associated with relationship difficulties, and situations where she perceived she had been strongly criticized, let down, or rejected. Not all such experiences were followed by depressive swings. However, the early warning symptoms that suggested she might go on to experience a major depressive disorder were: reduced energy and feeling slowed down (about four weeks prior to relapse); frequent bouts of crying for no apparent reason (three weeks); social withdrawal (one week); and early morning waking (one week). As shown in Table 6, Anne's action plan started with increased self-monitoring in response to her low energy. If she experienced bouts of crying, she redoubled her efforts to institute self-regulation approaches such as scheduling pleasurable activities and social contacts with individuals who made her feel more positive about herself. This helped pre-empt social withdrawal. If she continued to slide into depression, she introduced more intensive thought modification strategies and also began treatment with an anti-depressant. She arranged to bring forward her three-monthly outpatient clinic appointment.

Table 6 Anne's relapse prevention plan for depression

Triggers	Activation of underlying beliefs about approval, being likeable, or perceived rejection
Early warning symptoms	Lack of energy (–4 wks) Bouts of crying (–3 wks) Social withdrawal (–1 wk) Early wakening (–1 wk)
Frequency of monitoring	Monthly if no triggers Every 2 weeks if triggers present Every 3 days if reduced energy
Action plan	Increase self-monitoring Increase self-regulation – schedule at least 2 pleasurable activities/day Make 1 social contact/day plus visiting Jane and Rachel weekly (support) Use thought records to record and modify negative automatic thoughts Reintroduce anti-depressants starting on fluoxetine 20mg daily Call Harcastle Clinic (023 615 3982) & ask for appointment within 2 wks
Copies given to	Dr Brown, Jane, Rachel

Andrew had a history of recurrent mood swings. His three most recent episodes had occurred in the last three years and had been hypomanic or manic swings. He noted that the timing of the episodes was virtually identical: all three had occurred around Christmas time. At this time of year Andrew was often busy trying to complete the annual reports for his company. He also received a substantial annual financial bonus. Andrew drank more alcohol and got less sleep at this time of year as he attended a number of Christmas parties. The prodromal phase of the highs lasted about 12 days, usually starting with difficulty getting off to sleep and increasing irritability (first five days), being overactive and more talkative (six to nine days), being preoccupied by a desire to cut his hair (ten days) and excessive spending (one to two days). It is noteworthy that Andrew reported one idiosyncratic symptom (desire to cut his hair) that recurred with each episode. Also, the excessive spending just about coincided with the beginning of the episode.

As shown in Table 7, Andrew drew up a basic action plan that included setting limits on his spending to prevent any financial problems. He also agreed to consider taking time off work if his mental state did not settle after one week of his action plan.

Having examined these tables, you may wish to use the blank templates in the Appendix (pp. 241–2) and try to record your action plans for highs and lows.

Table 7 Andrew's relapse prevention plan for hypomania

Triggers	Christmas time, increased pressure at work, increased alcohol intake, receiving Christmas bonus
Early warning symptoms	Difficulty getting off to sleep and increasing irritability (–12 days) Being overactive and more talkative (–6 days) Desire to cut my hair (–2 to 3 days) Excessive spending (–1 to 2 days)
Frequency of monitoring	Every 2 months February–September Every month October–January Every week mid-November to mid-December Every 2 days if sleep disturbed or irritable
Action plan	Increase self-monitoring Increase self-regulation – reduce alcohol intake, try to reinstitute regular bed time, use A & B list, increase calming activities Set ceiling on spending (give credit cards to my wife) Reintroduce anti-psychotic medication (ring Dr Jones for prescription) Consider time off work if no improvement Call Community Psychiatric Nurse (Jean 493 211, night-time on-call service 0341 876 430) for appointment within 5 days
Copies given to	Dr Jones, Jean, my wife

Practice!

Without wishing to overemphasize the point, it is important to feel confident that you can institute your action plan when it is most needed. To do this, you will need to know in detail how to implement each planned intervention. These skills are best attained by using the different self-monitoring and self-management techniques on a regular basis. There is no substitute for such practice. Also, when you are experiencing early warning symptoms, try to view the introduction of the action plan as an opportunity to test out your skills and to examine how well your proposed system works. When the symptoms have finally subsided, take the time to review how effective your plan was. It is particularly useful to explore any aspects of the plan that were unsuccessful. Do not be afraid to make changes. It is important to feel able to revise or modify the interventions so that they meet your needs.

With practice and experimentation, you may eventually be able to avert major mood swings. However, if you do manage to avert a relapse, this is not the time to relax and stop using cognitive and behavioral strategies. Remember that upswings are often immediately followed by downswings. Also, the early phase of recovery from a downswing is a time of high risk for a further downswing. It is important to remain vigilant and to maintain your basic self-monitoring and self-regulation approaches even if you are in the recovery phase following a mild episode.

Summary

- An effective relapse prevention package includes information about your:
 - relapse signature: *triggers* and *early warning symptoms*;
 - action plan: *self-monitoring*; *self-management*; *self-medication*; *mobilization of support*; *early contact with mental health services*.
- Each significant mood swing requires a separate relapse prevention package.
- When each package is complete, a copy should be distributed to selected individuals.
- *Details* of the package can be *written on a flash card* to allow you ready access to key information.
- The *frequency of monitoring* of the relapse signature *should vary* according to the potential risk of relapse. It is important not to be overconscientious, as this may increase your anxiety rather than enhance your sense of self-control.

Looking to the Future

If you have managed to use the self-regulation and self-management techniques described in this book, you may already have been able to reduce the severity of your mood swings, or even prevent an episode of mood disorder. Controlling the symptoms that have disrupted your life is certainly important. However, your well-being is not defined simply by greater stability in your mood or the absence of symptoms of mood disorder. The next step is to overcome problems that prevent you from feeling at ease with yourself and in your relationships. Further, you will need to feel confident that you can cope with day-to-day problems and have a sense of where your life is going.

The final chapter of this book aims to help you to begin this process by looking at your view of yourself, aspects of your relationships with others, and some of your day-to-day problems. Much of this discussion focuses on coping with the aftermath of previous mood swings or episodes of mood disorder. Lastly, it looks at setting goals for your future and suggests additional tips on how to be your own cognitive therapist.

Improving Your Self-Esteem

When you feel down, it is common to have negative automatic thoughts about yourself. However, some individuals report that they never feel totally at ease with themselves. This low self-esteem or lack of self-confidence may be a lifelong characteristic, predating any mood swings; or it may have arisen as a consequence of having repeated severe mood swings and difficulties in coming to terms with behavior during these episodes. In reality, many individuals with mood disorders have a long-standing fragile self-esteem that is further undermined by experiencing mood swings. There are a number of approaches to overcoming low self-esteem, and a detailed account can be found in Melanie Fennell's book in this series, *Overcoming Low Self-Esteem*. Later I will outline some useful ways to begin the process, but first it is important to identify unhelpful strategies that in the long term appear to have more disadvantages than advantages.

Unhelpful Strategies

If you lack self-confidence to start with, and then have repeated experience of mood

swings, it is easy to understand why you might employ various strategies to put painful thoughts about yourself at a distance. Unfortunately, there are some approaches that don't help individuals to cope effectively on a day-to-day basis. The three strategies that *do not* seem to help improve self-esteem are:

- trying to avoid thinking about what happened;
- trying to externalize the responsibility for the way you feel;
- trying to convince yourself that being slightly high will overcome your negative view of yourself.

Unhelpful strategy 1: avoidance – “If I don’t think about it, it’ll go away.” It is tempting to avoid thinking about previous episodes of mood disorder and refusing to look at any adverse consequences of your actions, for you or for others. While avoiding thinking about issues that make you feel unhappy about yourself may help you for a short time, there are two major problems with this approach. First, you are missing an opportunity to work out how to solve your problems and to reduce the chances of the same problems cropping up in the future. Second, to avoid thinking about what happened may mean avoiding any discussion or contact with individuals who knew about it and might comment. This will inevitably restrict your lifestyle and may actually mean you lose contact with some sources of support. In the long run, this may worsen rather than improve your self-image.

Unhelpful strategy 2: rejecting all responsibility – “It’s not my fault.” You are not 100 per cent responsible for some of your actions when you are unwell. There are times when individuals with mood disorders are clearly no longer able to control their actions and responses. However, it is equally true that you cannot reject all responsibility for what happens to you. No matter how many other factors play a role, shifting the responsibility to “the illness”, other people, mental health professionals, the hospital or the treatment, without exploring what you may be able to do to help yourself, is counterproductive.

If you subscribe to the view that everything in life is totally beyond your control, you are in danger of giving up on your future. This would be a tragedy, as there are many areas of your life that you can positively influence. Furthermore, establishing what you *can* control will help you develop a more positive view of yourself. For example, you are not responsible for the fact that you get mood swings, and you may not be able to stop them happening. However, you may be able to learn how to recognize your problems early and seek help before your symptoms progress to a dangerous level. In addition, you can control other aspects of your life in spite of your mood swings.

Lastly, blaming everyone or everything else is unhelpful to your self-esteem. Even if other people or services have not always acted in your favour, you cannot expect to control how they react in the future. Ultimately you can only be sure of changing *your own* role or actions. The important aspect is to understand what you can control and what you cannot, and to be clear about your responsibilities and those of others. As discussed later in this chapter, your degree of responsibility will rarely be either 0 per cent or 100 per cent.

Unhelpful strategy 3: “Who am I?” – basing your self-image on how you are during your highs Individuals who experience mania often think that their ideal “normal”

state is not euthymia but the early stages of a high. At this point they feel more productive and active, and often get positive feedback from those people around them who do not know that they have a mood disorder. Alas, basing your self-image on a temporary state is unrealistic and unhelpful, for two reasons. First, there is a danger that you are focusing only on the good aspects of highs – what about the disadvantages? Don't forget that the early stages of a high do not last for ever. This phase usually leads to a manic episode or to a depressive swing. Both outcomes have considerable negative effects for you or for other people. Second, positive feedback or admiration from others will not last if those individuals also see you when you are so high that your thinking becomes chaotic, your mood unpredictable, and your actions erratic. Their views of you will start to fit into the “yes, but” category: “Oh yes, he's capable of a fantastic work rate and can be the life and soul of the party; *but* sometimes he really loses control, the quality of his work deteriorates, and he goes too far and upsets lots of his colleagues.” A reputation of this kind is unlikely to help you feel positive about yourself.

Having highlighted some unhelpful strategies, we will now focus on approaches that may lead you in the long term to a more positive and stable view of yourself. To begin with we need to review the way you see yourself now, then look at how to cope with any negative consequences of recent mood swings.

Helpful Strategies: Back to Basics

The first steps in building up your self-esteem are

- to develop a realistic view of yourself;
- to reduce your over-dependency on others' opinions;
- to try to build a positive self-image.

Trying to develop a realistic view How well do you know yourself? You may feel bad about yourself, but, as we have discussed on many occasions earlier in this book, these feelings are often associated with negative automatic thoughts. To try to clarify in your own mind where any negative feelings come from, and how accurate any negative thoughts are, it is helpful to draw up a list of your personal strengths and weaknesses (a blank table for this purpose is provided in the Appendix on p. 243). To get started, here are a few questions that may help you:

- What do you like/dislike about yourself?
- What positive/negative qualities do you possess?
- What do other people like or dislike about you?
- How would others assess your strengths and weaknesses?
- What qualities do you like/dislike in other people? Do you share any of these qualities?

Try to be honest with yourself and to give equal attention to each question. Also, try to avoid global labels such as “I'm a terrible mother” or “I'm useless.” Even if you have such negative thoughts, try to be specific about why you have made this statement. This means exploring the evidence. For example, “I lost my temper with my children over nothing,” or “I have failed to deliver on promises I made to

people.” Now try to check whether the list contains any statements based on single events or experiences. Are you certain these represent persistent personality characteristics? If not, why do you think they should be included (you may have a particular reason)?

Next, explore whether you have any evidence to support each statement on your list. If not, can you justify including this item on your final list? When you have reviewed and revised what you have written, ask yourself the following questions: What do you learn about yourself from your list of strengths and weaknesses? If you showed this list to someone you trust or who knows you well, would they agree that this is a realistic appraisal? If you are not sure, could you ask them? Finally, can you write a two- or three-line summary about yourself? Try to identify your key strengths and weaknesses, and start your description by noting your good points. For example, “I am reliable and hardworking and people like my sense of humour, but I can show a low tolerance of frustration and sometimes expect too much of others.”

You cannot change your self-esteem overnight. However, by working on the list, you can begin to explore the following themes:

- How can I build upon my current strengths?
- How can I reduce the frequency of any negative actions or thoughts related to my weaknesses?
- Which weakness is the best one to start working on?
- What new, positive attitudes can I introduce to build further upon my strong points?

Focusing on these issues will help you feel more confident about who you are, and encourage you to begin to like yourself a little more.

Avoiding self-criticism As well as developing a more accurate view of yourself, it is helpful to look at how you assess yourself on a day-to-day basis. By all means set yourself realistic and acceptable standards, and by all means assess whether you have lived up to your expectations. However, try not to be overly self-critical. There is a myth that self-criticism motivates people. My clinical experience is that it does the opposite. Individuals who constantly find fault with their own actions become demoralized and find it hard to keep going in the face of increased stress. Making constructive and encouraging self-statements, on the other hand, can help you achieve your goals.

To overcome self-criticism, see if you can reframe your criticisms into more helpful statements that encourage you, rather than demand that you do certain things. If your internal critical voice is very powerful, imagine that it is a parrot sitting on your shoulder that is making these criticisms. I often suggest this to people in my clinics, and I then ask them what they would do about the parrot. The more generous ones say they would make it fly away; those who are really fed up say they would shoot it. Whichever method you personally prefer, the goal is simple: silence the internal critic!

Don't be over-dependent on the views of others Some individuals, rather than experiencing persistent low self-esteem, say that their self-image varies purely on the basis of the feedback they get from other people. Fluctuating self-esteem is as damaging as continuously low self-esteem, as it makes you vulnerable to more

extreme mood swings. While you should not ignore all feedback from others, it is important to see these comments in context. Ask yourself three questions:

- First, on a scale of 0 to 100, how sensitive are you to the views of others?
- Second, on a scale of 0 to 100, how critical are others of you?
- Third, do you give equal attention to positive and negative feedback?

If you explore your answers to these questions, you may be able to judge whether you are too vulnerable to other people's opinions, particularly critical comments.

If you are sufficiently clear in your own mind about your strengths and weaknesses and your sensitivity to criticism, you will be better able to evaluate the comments others make about you. Positive feedback will confirm your good points and negative feedback, although painful to hear, should not be too much of a shock. Remember that it is important to keep a balanced and realistic view. Don't overemphasize positive comments; by all means be pleased, but keep your feet on the ground. Getting too carried away could simply set you on the path to a high. Likewise, don't catastrophize about negative comments. Even if those comments are presented in a critical way and are difficult to accept, try to work out what that person is trying to tell you. Is there a grain of truth in their comments that you can learn from? Lastly, remember that your reaction to others' comments will be largely dictated by your automatic thoughts. You can manage your feelings by following the classic approaches for modifying such thoughts, starting with an examination of the evidence supporting or refuting the idea.

Test out alternative beliefs If the techniques outlined above do not help you develop a more realistic self-image, it may be that you are overly influenced by a fixed negative belief about yourself. If you are not sure whether this is happening, it might be worth re-reading the section on underlying beliefs and how these can influence your life (p. 40–50). You may also be able to identify beliefs you hold about yourself by reviewing your automatic thought records. Are there any particular themes to these thoughts that point toward a fixed view of yourself? Can you capture the belief in a few words, by completing the statement “I am . . .”? If you can identify a core negative belief about yourself, can you rate (on a 0 to 100 scale) how strongly you subscribe to that idea? Next, can you provide all the evidence from throughout your life that supports the accuracy of your negative view? What about evidence that goes against your belief? Reviewing this information, is this a realistic appraisal, or have you accepted this belief as true without ever thinking to challenge it?

Most individuals who take themselves through this series of questions find that their beliefs about themselves were based on relatively unreliable evidence. Knowing that your own belief is unhelpful will undoubtedly help you predict situations or events that you will find stressful. However, this information alone will not change how strongly you subscribe to this belief. It takes several months (probably about four to six) to start to change your underlying view of yourself.

The first step is to agree to explore the alternative view of yourself. For example, if you hold the belief that “I am unlovable,” rewrite this belief on a piece of paper as “I am lovable.” If you hold the belief “I am incompetent,” rewrite the statement as “I am competent.” Having reframed the statement thus, rate on a 0 to 100 scale how strongly you subscribe to this new belief. The likelihood is that you will give this alternative belief a very low rating. This is understandable, for throughout your

whole life so far you have unwillingly collected information to support your old view. However, from today, you have to try to collect and record *any* piece of information, no matter how small, that supports the new belief. Don't bother with the evidence *against* your new idea; you've been attending to that for years, and could fill a textbook with it!

The whole point of this exercise is to raise your awareness of any information in the environment that starts to support your alternative belief. Also, remember you are not aiming for perfection. It is unlikely you will ever believe 100 per cent that "I am lovable." However, you may conclude that some individuals find you lovable most of the time. Likewise, being totally competent is unrealistic; try to aim for an acceptable and reasonable level of competency. A blank "alternative belief" schedule is provided in the Appendix on p. 244.

Your Personal First Aid Kit: Trauma Minimization

Having worked through the exercises just described, many individuals find that any remaining negative views of themselves are largely dictated by problems in coming to terms with the consequences of severe mood swings or episodes of mood disorder. They feel robbed of their future, are ashamed of some of what they are, and feel stigmatized because of their ill health. The key to coping with these problems is to try to minimize the trauma associated with the changes that you feel have been imposed on your life. Again, it is unhelpful simply to avoid thinking about these issues, or to get angry. It is more productive to start self-help and deal with the consequences as best you can.

Grief and loss Some individuals experience severe mood swings or a mood disorder that disrupt their functioning so gravely that they are no longer able to complete college courses or carry on in their employment. These unexpected restrictions not only affect their immediate activities, but may also change their career prospects and/or the future course of their lives. Many who have had such an experience feel they have become different people, and grieve for their "lost selves", the people they used to be. This is both common and understandable. These experiences can be compared with bereavement, and are compounded by the very real losses that can be associated with having a significant mental health problem, such as loss of income or status. Others find that there are major tensions in their personal lives, sometimes leading to the break-up of important relationships.

If these things happen to you, there is no benefit in trying to underplay the difficulties created by your recurrent mood swings. You will need time to recover from your disappointments, to adjust to your new situation, and to move forward. There are a number of key steps that will help you begin this coping process:

- Try to be clear about which problems are genuinely related to mood swings. As with any grief reaction, the real losses will take time to come to terms with. Don't complicate the process by overgeneralizing (as described in the section on thinking errors on p. 48–9) and attributing every negative event in your life to your mood disorder. For one thing, this is unlikely to be 100 per cent true; but more importantly, it is unhelpful, and will increase the risk of your giving up on your future.
- Avoid focusing on the "unfairness" of life. Life certainly is unfair in many ways;

but it is unhelpful to spend too much time concentrating on something you can't change. Preoccupation with what has already occurred may simply feed your anger and prevent you implementing strategies that help you move forward.

- Don't pretend it hasn't happened. Avoidance of this kind is likely simply to store up problems for the future. At some point you will have to examine what has happened, and what you can do to improve your situation. The problems will not disappear if you ignore them.
- Another way of avoiding the reality is to label yourself as the "illness". For example, avoid introducing yourself as "I'm a manic depressive." Don't deny the problem, but try to remember that there is more to your identity than a mood disorder. Sometimes you will need to remind yourself of this, and it is important to make others aware of it as well.

You will not overcome your grief or sense of loss with these strategies; but they will create the right conditions for you to start the process of adjustment.

One other loss that needs to be mentioned is "missing highs". Many individuals report that they are only too glad to be free of depression, but genuinely miss the buzz that they get from a high. As discussed earlier in this chapter, it is important to replace an unrealistic existence with a realistic one. However, like an addiction to a drug, your highs will not be easy to give up simply because it seems a sensible idea. You might like to try to reduce your dependency on highs by using a step-by-step approach similar to a "harm reduction" programme, making gradual changes to the degree of upswing in your mood that are acceptable – for example, you might start by only agreeing to take action when your mood rating is +4, then gradually move toward taking action at +3 and finally at +2 (or the agreed boundary between your normal and abnormal states). You will also need to look carefully at how to compensate for the loss of this experience from your life. For example, what activities or roles can you take on that give you a similar positive feeling about yourself?

Shame and guilt A common reason why individuals struggle to move forward is that they feel guilty about the way they used to behave or are ashamed of themselves. Greenberger and Padesky, in their book called *Mind over Mood*, point out that guilt and shame are closely linked emotions. Both are usually associated with a belief that we have violated our own rules about how individuals should behave, that we have failed to live up to our own standards or have been disgraced in the eyes of others. Coping with these thoughts and emotions is difficult; as with other problems we have discussed in this book, the starting point is to acknowledge to yourself what has occurred and then to evaluate the facts of the situation.

First, try to give yourself some positive feedback for choosing to face the problem and not avoiding it. When bad things happen it is easy to understand why the last thing you want to do is think about them. However, it is equally unhelpful to let any negative thoughts go around and around in your mind. Try to take a problem-solving approach and focus on what you need to do about what happened.

The second step is to record on a piece of paper exactly what occurred – what was the event that makes you feel guilty or ashamed. Greenberger and Padesky suggest that you then list everything and everybody who contributed or *might have* contributed to this outcome. Put yourself at the *bottom* of the list. Next draw a big

circle on the paper. Starting at the top of the list, divide the circle up into segments of different sizes according to the degree of responsibility that should be attributed to each circumstance and each person involved. The greater the responsibility, the bigger the piece of the pie. (A blank template is provided in the Appendix on p. 245.)

Having done this exercise, consider how much of the responsibility is yours and yours alone. Do you share responsibility with anyone else, and/or did your mood disorder play any part in the event? If you are not totally responsible, does this change how badly you feel about what occurred? Is there anything that you can learn from this experience, or anything that you can do to overcome any difficulties that have occurred?

If the “responsibility pie” suggests that you shoulder most of the responsibility, examine the details of what happened and try to answer the following questions:

- How serious was the incident? Does my assessment concur with that of other people? (If others think it is less/more serious, can you determine why that is?)
- If some one I cared about had acted this way toward me, how would I view the situation?
- In the longer term (e.g. in six months, in six years), how important will this incident be?
- When I acted in that way, was I aware of the consequences?
- What have I learned and how can I avoid similar incidents in the future?
- What damage has occurred because of what I did?
- What can I do now to start to repair the damage?
- Can I predict (accurately) some of the likely responses of individuals to my attempts to repair the damage? What strategies can I use to help me cope if they are finding it hard to forgive me? What will I do to cope with my own reactions/disappointments?

It is important to try to work through these questions before doing anything. However, don’t fall into the trap of becoming more and more negative about yourself. If this starts to happen, you can try to tackle your automatic thoughts; alternatively, try to focus on a “task-orientating” statement such as “Doing a bad thing does not prove that I am a bad person” or “Having done a bad thing in the past does not mean I cannot change how I act in the future.” You may wish to talk through with a trusted confidant any actions you think might repair the damage. Getting feedback at this stage may increase your chances of achieving a successful outcome.

Stigma Many individuals feel that their status in society is undermined by the negative views about mental health problems expressed by the public at large. Alas, these prejudices do impact on the lives of many people and will not be removed overnight. But, as you cannot control what others believe or how they view mental health problems, it is unhelpful to target all your energies on them. I am not saying you don’t try to play your part in tackling stigma, but the first action that is required is to focus on whether you hold any prejudices against yourself. If you are a perfectionist, do you now see yourself as “defective”? If you have a desire to be liked or approved of by others (and most of us do), do you fear that you will be rejected? Does this fear of rejection turn from sadness into anger? If these ideas are operating, you may need to review your own beliefs and think about how to tackle the

disappointment you feel about yourself. This will probably start with a review of methods of improving your self-esteem. Also, remember that anger often arises as a secondary reaction; you may need to work on the primary emotion, which may be hurt or sadness.

Relationships with Others

Clearly it is not possible to deal with all aspects of interpersonal relationships in this short section; the topic has after all been the subject of many books on its own. However, I will briefly comment on three areas that are worth considering:

- communication problems;
- assertion;
- sharing responsibility, including working with professionals.

Communication

Most of the time, we pay scant attention to the process of our interactions with other people. However, it is important to try to understand this process, particularly if you wish to pre-empt problems in relationships. Here are some guidelines for tackling inter-personal problems:

- Take your time to think about what you need to say and what issue you are trying to get across.
- Be clear and specific about the problem, but make sure you own it. Avoid placing all the responsibility on the other person. Stating “You’re ruining our relationship” is too general and seems to be blaming them. It may lead to the other person defending themselves against a perceived criticism, or angrily suggesting that you “sort yourself out”.
- Avoid sweeping statements. “Always” and “never” are key words to ban from the conversation. Other unhelpful statements include “If you loved me you would . . .” or “If you cared about me you wouldn’t have . . .”.
- Try to develop a shared view of the problem. If you don’t agree on the problem, you will never agree on the solution.
- Be a good listener. Don’t interrupt people and don’t tell them they’re wrong. Remember they are expressing their opinions or feelings.
- Retain your perspective. If the conversation is getting heated, be prepared to negotiate some time out so that both of you can review where the conversation is going and can steer it back on track.
- Try to stay calm. If you get angry, you may begin to use words you regret. Likewise, if you are very distressed, it is hard to come to a shared view of what to do next.
- Try to take a step-by-step approach to any agreed action, and set a time when you can both discuss the progress you have made.
- Give to get. Be prepared to play an active role in finding the solution, even if this means giving something up. Don’t expect the other person to “give to get” or to do all the giving.
- Be willing to try a solution suggested by someone else; don’t simply push the

other person to follow your proposed course of action.

You will not manage to follow these guidelines all the time, but if you bear these ideas in mind you may get nearer to a solution than you have in the past. Lastly, don't be afraid to suggest that you jointly seek help. This is particularly true if you are both struggling to overcome negative or distressing feelings, or if it is not possible to reach a shared view of the problem or the solution. A third party can often help keep a situation calm and help you focus on expressing your views in a constructive way, rather than falling into the trap of attacking the views expressed by someone else.

Assertion

Assertion is one aspect of clear communication. If you have ever been on the receiving end of someone's anger, you will know that anger rarely helps solve a problem. For a start, you may feel unsettled or quite frightened, and second, it's usually difficult to focus on or understand what the person is trying to say. So expressing yourself through anger is unlikely to help you get your need met. At the other end of the spectrum, it is equally true that you can end up feeling very frustrated or unhappy if you find yourself doing things you did not wish to because you failed to speak up and state what your needs were.

Basically, expressing your views either too forcefully or too meekly leads to problems. To strike the right balance, you have to learn to express your preferences clearly and calmly, and to negotiate with others effectively. The basic rules of assertion are:

- Have respect for yourself and recognize your own needs.
- Be prepared to ask for what you want.
- When expressing your opinions or feelings, always use "I" statements.
- If you are unsure about a proposal, ask for time to think it through; avoid being pressured into instant decisions.
- Remember that you can change your mind, but if you do, try to give people clear warning and an explanation.
- Recognize that you are responsible for your own actions, but that you cannot completely control those of other adults.
- Respect that other people have the right to apply the same rules of assertion to their own situations.

Getting this process right takes time. Practice helps, particularly if you have been prone to getting angry in the past, or have lacked the confidence to express your own needs.

Sharing Responsibility for Problems and Solutions

We noted earlier that at some point you may wish to repair any damage done to relationships as a consequence of behavior that occurred during your mood swings. This conversation often begins with you accepting a lot of the responsibility, or for not acting sooner to avert problems. However, this dialogue also allows you to hear other people's opinions on what they may be able to do to help. Rather than instantly

rejecting the opportunity to have others involved, take time to think about the advantages and disadvantages. Are there any benefits in their playing a role in helping you overcome your mood swings? Can they help you with any of your other problems? Will it actually improve your relationship if a particular person has a greater understanding of your problems and a clear role in supporting you? No one can make you accept any of these offers, but it is worthwhile considering the pros and cons. There is no rule that says you should always cope on your own.

Working on Your Problems with Professionals

A special case in sharing responsibility relates to how you work with health care professionals. Many individuals with mood disorders report enabling and collaborative relationships; others are disappointed. The frustrations of the latter often relate to thoughts that the doctor or professional they are in contact with does not have a clear understanding of their own situation, problems, and needs. If you hit problems, try to remember that this is a clash between two experts. You are an expert on how mood disorders affect you. You have a *depth* of knowledge about your own special circumstances that it would be hard for anyone else to attain. The other person is an expert on mental health in general and will have seen many individuals with similar (but not the same) problems associated with mood disorders. They have a *breadth* of knowledge about mood disorders that you may never develop. Sharing responsibility means that you are both clear about the aims of treatment and are both working toward the same goals. In this relationship, you are entitled to respect, information, and choice. In return, you must try to respect the other person's opinion and the advice they offer. Sharing the knowledge you both have and then coming to an informed decision is worthwhile, but can be very hard work for both parties. Remember the guidelines for communication also apply to this situation!

Setting Goals for the Future

You will probably have at least a vague sense of where you would like to be in the future, and some views on how you would like your life to be. If you are to turn these aspirations into tangible goals, you have to be able to describe them in more specific terms and also to determine how realistic the goals are. To help begin this process try to complete this statement:

"I will know that I am well when I am [doing the following . . .]"

This approach is similar to that used to create your symptom profile, but you are now trying to develop a *well-being profile*. A template is provided in the Appendix for you to complete (p. 246). Some individuals prefer to divide the list into separate areas, such as: basic day-to-day functioning (e.g. "I will be in full-time employment"); interpersonal functioning (e.g. I will have developed a social network"); view of self (e.g. "I will be at ease with myself").

Having created this profile, identify which issues you are already working on and which still need to be acted upon. You may wish to list these outstanding issues in order of priority. It is helpful to start with any basic problems, particularly those relating to the aftermath of any recent mood swings. Next, check that each item on

the list is written as a goal rather than a problem. For example, financial problems can be defined as a goal to “reorganize my monthly spending and set money aside so that I can pay off my overdraft by June 2002”. This goal demonstrates two key components: first it is *specific*; and second, it sets a clear *target*. The next questions you must ask are: “Is my goal realistic; is it achievable?” The final question is: “How will I measure my progress?” In the example given, you might set sub-goals for how much of your overdraft you will pay off per month, or how much will be paid off during each six-month period.

Once you have identified a specific, realistic, and achievable goal and know how you will measure your progress, you next need to establish the steps required to achieve this goal and then to set an appropriate time-frame. To generate the steps, try to use the problem-solving techniques described earlier. If the goal is likely to take some time to achieve, for example returning to full-time employment, you may also wish to set some sub-goals. These sub-goals represent important steps along the way to your target. They also allow you to further divide the task into more manageable units and to detail the steps required between each sub-goal. You can then assess how far you expect to get in the short, medium, or long term.

As well as working out a detailed action plan, you will also need to identify any obvious hurdles or barriers to achieving your goal, and brainstorm a list of the potential ways to overcome those problems. Finally, set a specific time to start working on the first step toward your goal, and note the cues that will keep you on track and focused.

An Example of Goal-Setting

To help you gauge whether you have understood this approach, you may like to work through the following example:

Geoffrey has recently recovered from a depressive episode. He has been able to use a number of self-management strategies to cope with his problems and is feeling more optimistic about the future. He currently attends a day centre two days a week, but has difficulty filling the rest of his time. He wants to return to full-time employment as a salesman. He realizes this will take some time, so he identifies his future goal as: “To return to full-time employment as a salesman or in a related job, within nine months.”

Can you describe the course of action Geoffrey might take? After you have tried to do this, you may like to compare your approach with the plan I have described in Box 12. Obviously, there is no absolute right or wrong way to tackle the problem, and your version may differ from mine. Whatever your chosen route, try to remember to describe every step you think is required in detail. A good test is whether someone who read your plan could follow it and reach the desired endpoint. If not, which parts have you identified in your mind but not written down?

If you feel comfortable with this approach, you may like to work through your own list of future goals and begin to describe the action plan for each of them. A template for pursuing this idea is provided in the Appendix on p. 247.

Being Your Own Cognitive Therapist

One of the issues raised in the discussion of future goals above was the need for cues that will help you keep on track. It is only human to show some variability in your commitment to working on a personal target. Like many other people, you may find you are more interested in applying self-help strategies when you have symptoms or problems. Your enthusiasm to write notes, tackle automatic thoughts, or work on other issues may recede if you are feeling a bit better and do not see any immediate difficulties on the horizon. However, it is worth thinking about how you can tackle this natural tendency and gain the maximum benefit from the approaches we have discussed. If there were a therapist present, they would probably alert you to three issues:

- doing the basic minimum to maintain your current state;
- dealing with setbacks;
- scheduling therapy sessions regularly.

Minimum Maintenance

If your mood is stable and you have no immediate goals you wish to work on, should you give up using self-help? The obvious answer any cognitive therapist would give is no. However, you may be able to tailor the use of the techniques to fit in with your preferences. There are two elements to this strategy.

First, don't stop using all of the techniques. The interventions that got you well will help keep you well. Hence it would be foolish to stop self-regulation or any key approach that has really been of benefit. Try to identify the minimum number of techniques you are prepared to continue using, and then push yourself to keep them going. This is important as you need to feel able to increase the use of these or similar techniques in response to change. Lack of practice may reduce your confidence in using the technique when under stress.

Box 12 Geoffrey's plan for returning to work	
<p><i>My goal is:</i></p> <p>To return to work as a salesman (or similar)</p> <p>The date I aim to achieve this goal by is: Oct 2002 (9 months from now)</p>	
<p><i>Sub-goal 1:</i> Be able to cope with a full daily routine by the end of February</p> <ul style="list-style-type: none"> • start by increasing activities on days when I'm not at the centre • increase activity scheduling • work on self-regulation 	<p><i>Subgoal 4:</i> Start reviewing job adverts from May onwards</p> <ul style="list-style-type: none"> • Order newspapers for Tues and Thurs when travelling salesman jobs are advertised • Send for a few of the application packs to see what they're asking for
<p><i>Sub-goal 2:</i> Write my CV or resumé, so that I can apply for jobs when they're advertised, by end of March</p> <ul style="list-style-type: none"> • Get my old CV out and update it • Ask Gerald to show me how to use his computer to make CV look professional • Ask Bob to check it over to see if it reads well • Get copies made <p>NB: Also start to work on my self-esteem a bit more; I need to come across as a bit more confident at interview</p>	<p><i>Sub-goal 5:</i> Start applying for jobs in June</p> <ul style="list-style-type: none"> • Make sure I've got an interview suit • Keep working through the things I did with Bob • Keep working on self-esteem <p>Have a fallback plan – even if I get lots of interviews I can't guarantee I'll get appointed – I need a plan of how to spend my time in a meaningful way; also, I may need to meet with a career adviser or join a job club to start to think of any other options for after September</p>
<p><i>Sub-goal 3:</i> Rehearse interviews with Bob during April so that I feel ok about the questions and can start to work on my answers</p> <p>Also keep working on self-regulation and self-esteem</p>	<p><i>Sub-goal 6:</i> June–Sept – apply for posts and attend interviews with view to starting in October</p> <p>Also – work out who to get personal support from during this time, particularly as I'll probably have to have a few interviews before I get the chance of a job</p>

Second, there is a minimum set of commitments that you should try to make in order to maintain your well-being:

- A: Awareness of the key features of your mood swings and the associated symptoms and problems.
- R: Recognizing your relapse signature or when your problems are escalating.
- T: Taking *early* action to deal with problems or potential relapses, including

seeking help from others.

This approach is described as the ART of well-being.

Dealing with Setbacks

It is unlikely that you will go through all the approaches in this book and never hit a problem or setback. Try not to panic or catastrophize; stay as calm as you can, and reflect on what has happened. Next try to work through the following steps:

- Using notes you have made or information in this book, try to determine how this setback has arisen and how you might cope with it.
- Write down any techniques that you might use at this moment, e.g. activity scheduling, calming activities, problem-solving.
- What negative automatic thoughts may be contributing to how you are feeling?
- Can you write down any automatic thoughts, and can you challenge the most powerful thoughts?
- What underlying beliefs may have been activated?
- Are there any behavioral or cognitive strategies that you could use to help you cope with this situation?
- Can you list the range of interventions that you could try?
- Can you put these in order of priority and begin with the first approach on the list?
- If none of the above approaches seem to help, who can you talk with to help you deal with this problem and how it has made you feel?

Try to take a problem-solving stance to a setback; giving up is not a helpful approach, no matter how strong your wish to stop trying. Dealing with any negative thoughts and feelings is particularly important, as this may clarify what the real issues are and allow you to work out what steps you need to take next.

Scheduling Sessions with Yourself

If you were engaged in a course of cognitive therapy you would probably have a regular appointment to see your therapist that you had both agreed in advance. One way to keep focused when working on your own is to schedule appointments with yourself! For example, rather than reviewing progress on self-regulation in an *ad hoc* way, you set time aside every week to monitor your progress and review what to do next. Fixing a time each week is also a way of valuing yourself and looking at your own needs. If self-help approaches are important to you, you owe it to yourself to find a reasonable amount of time to devote to them to increase the likelihood of making them work for you. Merely fitting any review into a spare ten minutes at the end of a tiring day is not giving yourself the best chance of benefiting from the approaches.

If you decide to plan some appointments with yourself, try setting aside about 45 minutes on a regular day each week. Next, try to set an agenda for the session, so that you are clear what aspect of your self-help programme you want to review. A typical schedule is described in Box 13. Obviously, you may not wish to address all the questions listed here; this template can be adapted to your own needs and preferences. It is worth retaining the same items at the beginning and end of the

session: that is, start each week with a review of progress since the previous week and end with a clear set of tasks for the next week.

Box 13 Possible agenda for sessions with yourself

Date:

Current mood ratings:

Possible agenda items

- 1 Review tasks set last week and write a few sentences on what I have learned.
- 2 What symptoms or problems do I have currently?
What techniques can I use to deal with them?
- 3 What goals do I have?
Am I making progress?
What barriers have I encountered or do I need to be aware of in the coming weeks?
What skills do I have to overcome these problems?
- 4 What areas still keep me vulnerable?
- 5 What areas do I still need to work on and how am I going to do this?
- 6 What tasks do I need to address in the coming week?
What can I do if I encounter any setbacks?

Write brief notes on the session and ensure time is set aside in diary for next session.

As with any therapy, you may be able to spread out your sessions as you feel that the cognitive and behavioral strategies become second nature. However, if you always find an excuse for not doing your sessions you may also like to explore the thoughts that are linked to your reluctance.

Taking Control

I hope that this final chapter has given you some ideas about how to move forward in the future. The cognitive and behavioral strategies that may reduce the risk of further mood swings can also be applied to other aspects of your life. Remember, it is more constructive to regard each attempt to use these techniques as an experiment rather than as a test to be passed or failed. Be kind to yourself if you can't always follow the plan you have set at first. Getting rid of the internal critic and setting the other conditions for improving your self-esteem are important initial steps. This will allow you to address your future goals in a more positive and realistic frame of mind. Finally, remember that the key to overcoming mood swings is being clear what your own responsibilities are in dealing with these problems and then learning to control what you can control.

Summary

Looking to the future with confidence requires the following:

- Overcoming low *self-esteem* through:
 - developing a realistic appraisal of your strengths and weaknesses;
 - reducing self-criticism;
 - reducing reliance on the views of others;

- testing out alternative views of yourself.
- Overcoming poor *self-image* that arises as a consequence of mood swings by trauma minimization – applying personal first aid to deal with:
 - grief and loss;
 - guilt and shame;
 - stigma.
- Developing *strong relationships* through:
 - clear communication;
 - asserting *yourself*;
 - sharing responsibility if you choose.
- Developing *life goals* that are;
 - specific and realistic;
 - clearly defined in terms of steps or sub-goals;
 - recorded on a time schedule.
- Being your own CBT therapist, which may include the following:
 - subscribing to the ART of well-being approach
 - A: awareness of mood swings;
 - R: recognizing symptoms and problems;
 - T: taking early action;
 - dealing effectively with setbacks;
 - scheduling therapy sessions with yourself.

Useful References

I have tried to restrain myself from offering too many references. I have selected a few books about individuals who have mood disorders, but the majority of the works listed below are user guides or self-help manuals that may be helpful in further developing your understanding of mood disorders and help your CBT skills. Where no layperson's guide exists, I have identified clinical books that you may like to browse. Lastly, for completeness, I have noted a few standard textbooks that you may like to dip into from time to time.

Books about Individuals with Bipolar Disorders

Kay R. Jamison, *Touched with Fire: Manic Depressive Illness and the Artistic Temperament*, New York: Free Press, 1993

Kay R. Jamison, *An Unquiet Mind: A Memoir of Moods and Madness*, New York: Knopf, 1995

Books about Mood Disorders

American Medical Association, *Essential Guide to Depression*, New York: Pocket Books, 1998

Nancy Andreasen, *The Broken Brain: The Biological Revolution in Psychiatry*, New York: Harper-Perennial, 1984

Lawrence Chilnick (ed.), *The Pill Book*, New York: Bantam Books, 1996 (6th edn)

Brian L. Court and Gerald E. Nelson, *Bipolar Puzzle Solution: A Mental Health Client's Perspective*, London: Taylor & Francis, 1996

Allen Frances and Michael B. First, *Your Mental Health: A Layman's Guide to the Psychiatrist's Bible (The diagnostic and statistical manual)*, New York: Scribner, 1998

Jack Gorman *The Essential Guide to Psychiatric Drugs*, London: St Martins Press, 1992

Peter C. Whybrow, *A Mood Apart: The Thinker's Guide to Emotion and its Disorders*, New York: HarperCollins, 1997

Self-Help Books

Robert Alberti and Michael Emmons, *Your Perfect Right: A Guide to Assertive Living*, California: Impact Publications, 1982

- Aaron T. Beck, *Cognitive Therapy and the Emotional Disorders*, London: Penguin Books, 1989 (first pub. International Universities Press, 1976)
- Aaron T. Beck, *Love is Never Enough: How Couples Can Overcome Misunderstandings, Resolve Conflicts and Solve Relationship Problems Through Cognitive Therapy*, London: Penguin Books, 1989
- David D. Burns, *The Feeling Good Handbook*, New York: Plume/Penguin Books, 1990
- Mary Ellen Copeland, *Living Without Depression and Manic Depression: A Workbook for Maintaining Mood Stability*, California: New Harbinger, 1994
- Mary Ellen Copeland, *The Depression Workbook: A Guide for Living with Depression and Manic Depression*, Vermont: Peach Press, 1992
- Melanie Fennell, *Overcoming Low Self-Esteem*, London: Robinson, 1999
- Paul Gilbert, *Overcoming Depression: A Self-Help Guide Using Cognitive Behavioral Techniques*, London: Robinson, 1997
- Dennis Greenberger and Christine A. Padesky, *Mind Over Mood: A Cognitive Therapy Manual for Clients*, New York: Guilford Press, 1995
- Paul Wilson, *Instant Calm*, New York: Penguin Books, 1995

Textbooks

- Samuel H. Barondes, *Mood Genes: Hunting for the Origins of Mania and Depression*, New York: W. H. Freeman, 1998
- Fredrick Goodwin and Kay R. Jamison, *Manic Depressive Illness*, Oxford: Oxford University Press, 1990
- Eugene Paykel, *Handbook of Affective Disorders*, Cambridge: Cambridge University Press, 1992
- Stephen Stahl, *Essential Psychopharmacology of Depression and Bipolar Disorder*, Cambridge: Cambridge University Press, 2000

Cognitive Therapy Textbooks

- Monica Basco and John Rush, *Cognitive Behavior Therapy for Bipolar Disorder*, New York: Guilford Press, 1995
- Mark Bauer and Linda McBride, *Structured Group Psychotherapy for Bipolar Disorder: The Life Goals Programme*, New York: Springer, 1996
- Aaron T. Beck and colleagues, *Cognitive Therapy for Depression*, New York: Guilford Press, 1979
- Dominic Lam and colleagues, *Cognitive Therapy for Bipolar Disorder: A Therapist's Guide to Concept, Methods and Practice*, Chichester: John Wiley, 1999

Useful Addresses

There are many organizations that produce written materials, such as leaflets and booklets, or offer conferences or local self-help group meetings. In Britain, the Manic Depression Fellowship has produced some excellent booklets, as has the National Depressive and Manic Depressive Association in the USA. Both organizations are well worth contacting.

Rather than produce an unending list, I have selected organizations on the basis of my own knowledge of their publications, their ability to point people in the right direction with regard to treatment or self-help, and my own experiences of working with them. You may wish to contact them to get additional information or to learn about activities they are engaged in. Finally, I have also listed a couple of websites that display up-to-date information.

British Association of Behavioural and Cognitive Psychotherapies

Executive Officer
PO Box 9
Accrington BB5 2GD
UK

Tel/fax: 01254 875277
Email: babcp.org.uk

British Psychological Society

Division of Clinical Psychology
St Andrew's House
48 Princess Road East
Leicester LE1 7DR
UK

Tel: 0116 254 9568
Fax: 0116 247 0787
Email: mail@bps.org.uk

Beck Institute of Cognitive Therapy

1 Belmont Ave, Suite 700
Bala Cynwyd
PA 19004-1610
USA

Tel: 00 1 610 664 3020
Fax: 00 1 610 664 4437
Email: beckinst@grim.net

Calipso Self-Help and Mental Health Library

c/o Stephen Taylor-Parker
175 Woodhouse Lane

Leeds
LS2 9LT
UK

Website: www.calipso.co.uk

Depression Alliance

35 Westminster Bridge Road
London
SE1 7JB
UK

Tel: 020 7633 0557
Fax: 020 7633 0559
Website: www.depressionalliance.org

International Association of Cognitive Psychotherapy

c/o William Lyddon
Department of Psychology, Box 5025
University of Southern Mississippi
Hattiesburg
MS 39406-5025
USA

Tel: 00 1 601 266 4602
Fax: 00 1 601 266 5580

International Society of Bipolar Disorders (ISBD)

P O Box 7168
Pittsburgh
PA 15213-0168
USA

Tel: 00 1 412-383-4836
Fax: 00 1 412-383-4837
Email: carothersdj@msx.upmc.edu
Website: www.wpic.pitt.edu/isbd

Manic Depression Fellowship (MDF) National Office

Castle Works
21 St George Street
London
SE1 6ES
UK

Tel: 020 7793 2600
Fax: 020 7793 2639
Email: mdf@mdf.org.uk
Website: www.mdf.org.uk

MIND: The National Association for Mental Health

Granta House
15–19 Broadway
Stratford
London E15 4BQ
UK

Tel: 020 8519 2122

National Alliance for the Mentally Ill

200 North Glebe Road, Suite 1015
Arlington,
VA 22203-3754
USA

Tel: 00 1 703 524 7600
Fax: 1 800 950 NAMI (6264)

National Depressive and Manic Depressive Association (National DMDA)
730 Franklin Street, Suite 501
Chicago
IL 60610
USA

Tel: 00 1 312 642 0049
Fax: 312 642 7243
Website: www.ndmda.org

National Foundation for Depressive Illness, Inc. (NFDI)
P O Box 2257
New York
NY 10116-2257
USA

Tel: 00 1 800 248 4344

National Institute of Mental Health – Public Inquiries
6001 Executive Boulevard, Rm 8184
MSC 9663
Bethesda
MD 20892-9663
USA

Website: www.nimh.nih.gov/publicat/bipolar.htm

Royal College of Psychiatrists
17 Belgrave Square
London
SW1X 8PG
UK

Tel: 020 7235 8857
Fax: 020 7259 6507
Website: www.rcpsych.ac.uk

Websites

Bipolar Disorder Frequently Asked Questions File
www.moodswings.org/bdfaq.html

Cochrane Database of Systematic Reviews
biomed.niss.ac.uk/ovidweb/ovidweb.ag

Expert Consensus Guidelines Series
www.psychguides.com

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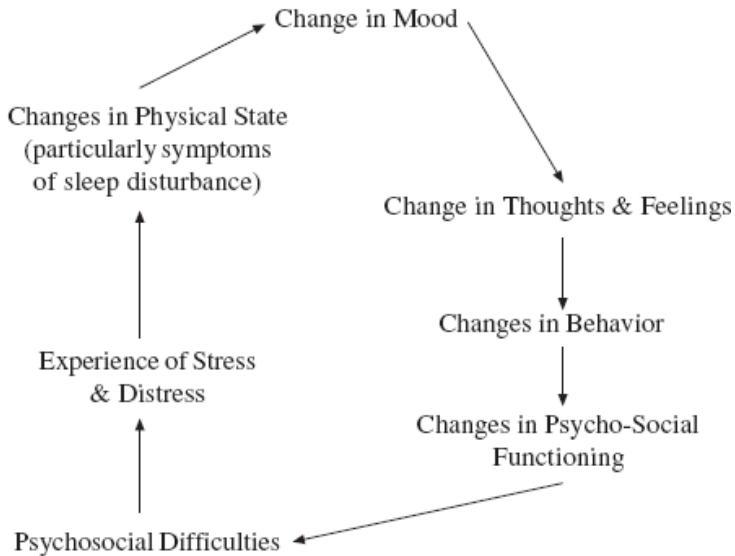
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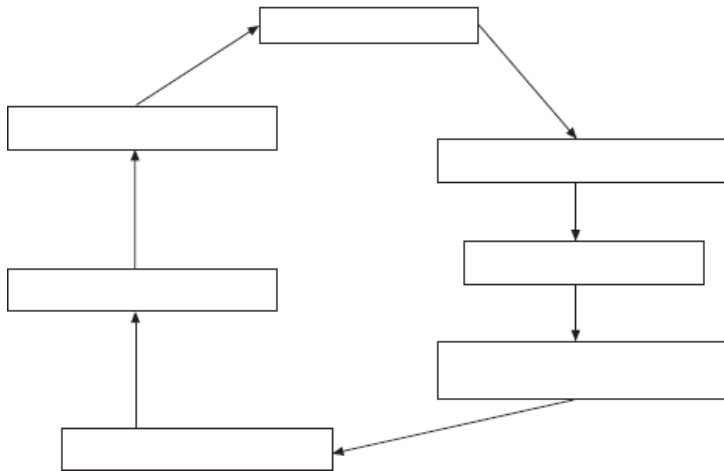
The cognitive behavioral cycle
My life chart
My symptom profile
My risk list
Alternative version of a risk list
Outline of a mood chart
Activity schedule
Self-regulation chart
Side-effects of mood stabilizers
My treatment plan
Template for a cost-benefit analysis
Activity matrix
Blank thought record
Two column technique for use when “high”
Relapse prevention plan
Summary of my strengths and weaknesses
Gathering evidence for alternative belief about myself
Responsibility pie
Well-being profile
Planning my future goals

The cognitive behavioral cycle (Figure 4 p. 51)

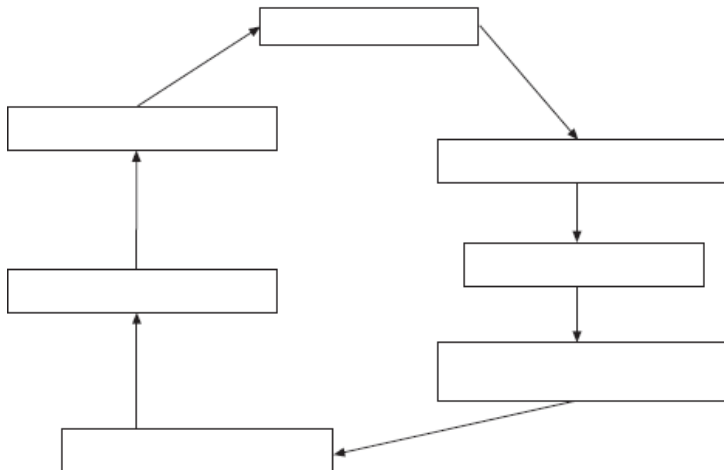


This diagram represents the key elements of the cognitive behavioral cycle. With this for guidance, try to complete your own cycle as it occurs during depressions and highs using the blank versions that follow. Try to start at the box that represents the first change that you notice e.g. changes in mood or stress and distress, etc. Then see if you can work your way round the diagrams filling in the blank boxes.

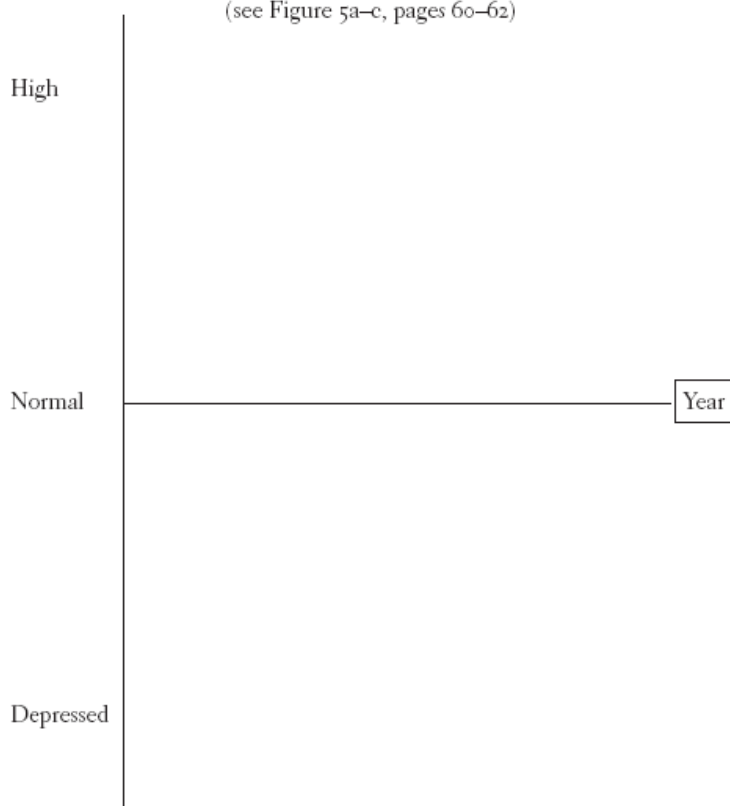
My Cognitive Behavioral Cycle: DEPRESSION



My Cognitive Behavioral Cycle: HIGHS



My life chart
(see Figure 5a–c, pages 60–62)



Add markers to indicate

- when treatments started, stopped, or changed
- when events or situations occurred that may be linked with the onset of episodes.

My symptom profile (see Table 2, p. 69)

<i>Highs</i>	<i>Depression</i>	<i>Mixed states or other mood swings</i>
My common symptoms* are:	My common symptoms* are:	My common symptoms* are:
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
My less common symptoms* are:	My less common symptoms* are:	My less common symptoms* are:
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6

* Put a star next to the symptoms or changes you notice *first*: these are your early warning symptoms

Risk factors

1 High-risk activities

2 High-risk situations

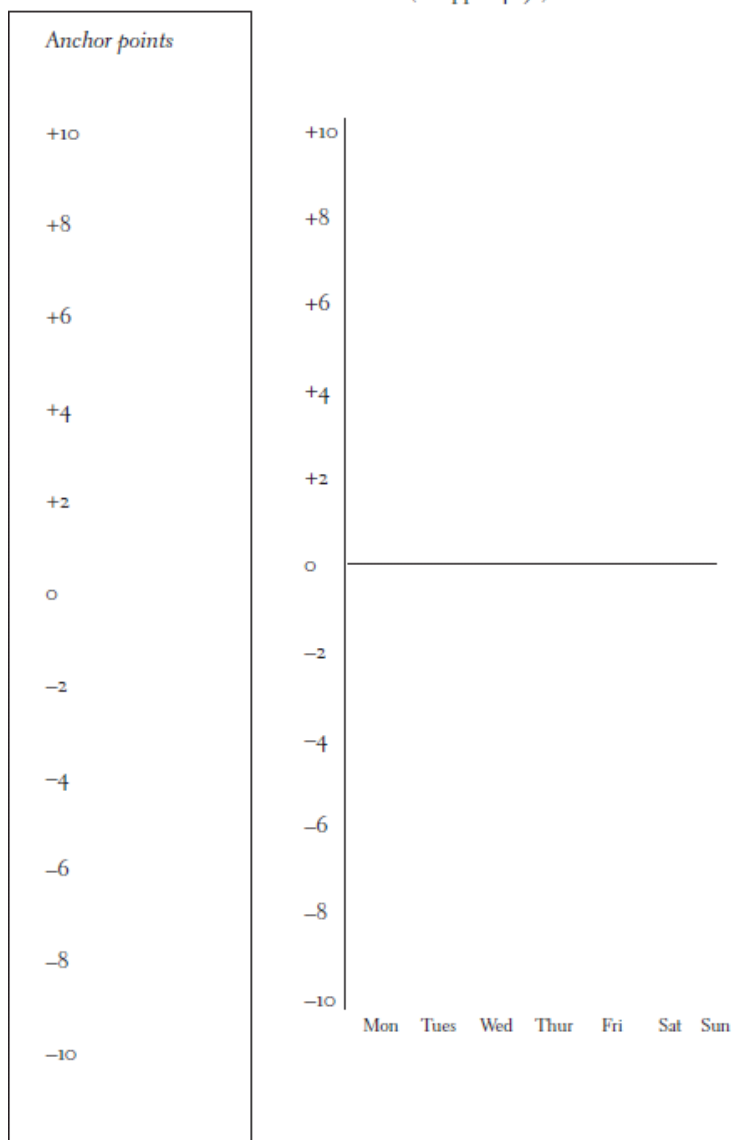
3 High-risk events

Other important information

e.g. High-risk combinations

e.g. Protective factors

Outline of a mood chart (see pp. 84–92)



Activity schedule (see pp. 92–97)

Use P ratings to represent *pleasure* (0–10 or 0–100)

Use A ratings to represent a sense of *achievement* (0–10 or 0–100)

Time	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
4–6 a.m.							
6–8 a.m.							
8–10 a.m.							
10 a.m.–12 noon							
12 noon–2 p.m.							
2–4 p.m.							
4–6 p.m.							
6–8 p.m.							
8–10 p.m.							
10 p.m.–midnight							
Midnight–4 a.m.							

You may prefer to redraw your schedule with each box representing one hour of activity during the day and have a single box representing 12 midnight to 7 or 9 a.m. Some individuals find this more useful as it gives them more space to record what they do during daylight hours.

Self-regulation chart (see Figure 9, page 101)

Activity*	Time**	Actual time did the activity						
		Mon	Tues	Wed	Thur	Fri	Sat	Sun
Getting up	Preferred							
Going to bed								

* Use the blank boxes to identify your chosen activities

** Put preferred time for undertaking activity opposite the horizontal line in column 2, then choose times about two hours either side of preferred time and record as a graph in column 3 the actual time the activity was undertaken each day.

Side-effects of mood stabilizers (see p. n6)

<i>Mood stabilizer</i>	<i>Common side-effects, particularly early in treatment</i>	<i>Longer-term side-effects</i>	<i>Rare, but potentially harmful side-effects</i>
Lithium	Tremor Muscle weakness Thirst Diarrhoea Stomach upset	Weight gain Thyroid problems Kidney problems	Lithium toxicity: vomiting, confusion, unsteadiness, difficulty speaking clearly
Carbamazepine	Headaches Dizziness Drowsiness Blurred vision Upset stomach	Reduced white blood cell count Changes in tests of liver functioning	Skin rashes Severe drop in white cell count
Sodium valproate	Upset stomach Diarrhoea Drowsiness Tremor	Hair thinning Weight gain Changes in tests of liver functioning	Liver damage

My treatment plan (pp. 122–4)

My treatment plan is to:

- Take the following prescribed medication:

Name of medication

Dose

Frequency

.....

.....

- Have contact with the following professionals:

Name of person

Frequency of contact

.....

.....

The benefits to me of this approach are:

•

•

•

•

The barriers to my sticking to this approach are:

•

•

•

•

The ways I might overcome these barriers are:

•

•

•

•

Template for a cost–benefit analysis (see pp. 127–9)

<p>Advantages of taking</p> <p>.....</p> <ul style="list-style-type: none">•••••••	<p>Disadvantages of taking</p> <p>.....</p> <ul style="list-style-type: none">•••••••
<p>Advantages of <i>not</i> taking</p> <p>.....</p> <ul style="list-style-type: none">•••••••	<p>Disadvantages of <i>not</i> taking</p> <p>.....</p> <ul style="list-style-type: none">•••••••

Thought record (see pp. 149–52)

It is helpful to refer to the questions listed in the text when trying to complete the different columns of the thought record

Situation or event	Emotion (rated 0–100)	Automatic thoughts (belief rated 0–100)	Evidence for and against the thought	Alternative view	Re-rate emotion and belief in original automatic thought	Action or outcome

Two-column technique for use when *high*: self versus others (see pp. 164–8)

Benefits to me	Risk of harm to others*

*Your goal when high is to concentrate on this column as these thoughts are less accessible to you unless you work hard to think of them

Two-column technique for use when *high*: constructive and destructive potential (see pp. 164–8)

Constructive potential	Destructive (damaging) potential*

*Your goal when high is to concentrate on this column as these thoughts are less accessible to you unless you work hard to think of them

Two-column technique for use when *high*: gains and losses
(see pp. 164–8)

Potential gains	Potential losses*

*Your goal when high is to concentrate on this column as these thoughts are less accessible to you unless you work hard to think of them

Triggers:

1

2

3

Early warning symptoms:

1

2

3

Frequency of monitoring:

Action plan:

1

2

3

Copies given to:

1

2

3

Triggers:

1

2

3

Early warning symptoms:

1

2

3

Frequency of monitoring:

Action plan:

1

2

3

Copies given to:

1

2

3

Summary of my strengths and weaknesses (see pp. 187–90)

My strengths	My weaknesses
Summary statement*	

*Write two or three lines that summarize your view of yourself, beginning with comments on your *strengths*.

Gathering evidence for my alternative belief about myself (see pp. 190–1)

My new belief to test is:

“ I am

My conviction that this belief is accurate is (0–100)

Date:

Evidence to support this belief

1

2

3

4

5

6

My conviction of this belief is now (0–100)

Date*:

Evidence to support this belief

7

8

9

10

11

12

My conviction of this belief is now (0–100)

Date*:

*Try to re-evaluate your conviction of this new belief at least every three months.

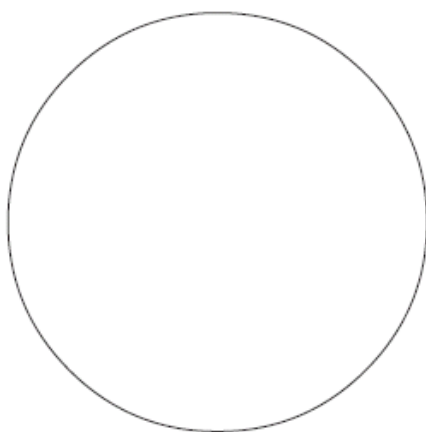
Responsibility pie (see p. 194)

- 1 Event that occurred:
- 2 Circumstances, situations, and/or people which *may* have contributed:

a
b
c
d
e
f
g

My contribution:

- 3 Responsibility of each of the above as a proportion of this pie:



- 4 Note your own assessment of your responsibility:
- 5 How does this exercise affect your feelings or your view of your responsibility?
- 6 What additional action could you take that may help overcome the consequences of what occurred?

Well-being profile (see p. 200)

I will know that I am well when I am doing the following:
Basic day-to-day functioning: 1 2 3 4 5
Interpersonal relationships: 1 2 3 4 5
Views of self: 1 2 3 4 5

Planning my future goals (see p. 202)

<i>My goal is:</i>	
<i>The date I aim to achieve this goal by is:</i>	
<i>Sub-goal 1:</i>	<i>Sub-goal 5:</i>
<i>Sub-goal 2:</i>	<i>Sub-goal 6:</i>
<i>Sub-goal 3:</i>	<i>Sub-goal 7:</i>
<i>Sub-goal 4:</i>	<i>Sub-goal 8:</i>

To use this template, write your goal in the top box, then record each major step as a sub-goal. Use the sub-goal boxes to write notes on what steps you need to complete before moving on to the next sub-goal.